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# ORIGINAL ARTICLES

## "THE DOCTOR'S LOG"


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*"Convictions and certainties are too often the concomitants of ignorance. If travel brings a conviction of human diversity, it also brings an equally strong conviction of human unity. It inculcates tolerance and shows what are the limits of possible toleration. Convinced by practical experience of man's diversity the traveller will not be tempted to cling to his own inherited national standard as though it were necessarily the only true and unperverted one. He will compare standards and he will search for what is common to all."*

*Understanding diversity, and allowing for it, he will tolerate, but not without limit."*

—Aldous Huxley.

*"A chiel's amang you taking notes and faith he'll print it."*

—Burns.

### AUSTRIA

These notes were started in the "Stube" of my old friend Herr Hugo Haas at his home called "Traunmuhle" in Syria, Salzkammergut, Austria and I am finishing them on the steamer homeward bound. The word "Salzkammergut" means "salt mine region." I wish it were possible for me to describe adequately this beautiful country with its mountains covered with green Christmas trees, the sky with its ever changing clouds, and the people in their national costumes who greet you in the road with "Gruss Gott"—God's Blessing. For the tired traveller there is no land that is quite so soothing. Comparatively few Americans come here, yet it is only eight hours from Vienna and six from Munich. Like our own lake regions the Salzkammergut is a goitre region. However the use of iodine salt is showing favorable results here as elsewhere. Nowhere have I seen such large goitres as in this region especially among those past middle age. Apparently the type common here does not affect the people adversely as they carry heavy loads and climb steep paths with ease. The government controls the salt industry as well as the railroads, posts, telephone, telegraph and sale of tobacco.

Austria has much of interest from a medical standpoint not only on account of Vienna, of which more later; nor account of history of goitre (there are still a few of the old goitre houses left) but because of its many springs the water of which is used in the treatment of diseases such as rheumatism in all its forms, skin diseases, female diseases. Such towns as Bad-Aussee, Bad-Gastien, Bad-Ische, Bad-Ischl, seat of the hunting and summer home of the late Emperor Frances Joseph, Alt-Aussee—the region round about Salzburg all are satisfactory places to take the various cures at reasonable prices.

In the little Spitalkirche or hospital church at Bad-Aussee is an old altar piece from the year 1449. The rest of the building is now used as a poor house. Of interest are the signs in the town Gasthaus zum Kaiser von Osterreich, the drug store with the name Apotek Goldner Adler, Weinstube, where only wine is sold, with its pictures of hunters and its walls decorated with the antlers of the deer and mountain goat. In the square is a monument with an inscription in German which explains itself. Translated it reads:

*"O good is God." He is eternally prized and Him we honor with thankfulness and erect this pillar; He saved us from the plague by his mercy in the year 1679."*

One enjoys a visit to Austria though even now reduced to a mere shadow of her former greatness. Visit Vienna by all means but do not forget the beautiful country and its other two interesting cities of Innsbruck with its history of Andrew Hofer called the George Washington of the Tyrol and the fascinating city of Salzburg with its memories of the two great men—Mozart in music and Paracelsus in medicine. There is a monument to Paracelsus in the old church of St. Sebastian. Paracelsus had a father who tutored him in medicine and at the same time searched for the "Philosopher's Stone." He studied disease wherever he could find it, in the streets, alleys and along roads in the country. He learned much in his talks with barbers, sow gelders, midwifes, gypsies and the lowly horseshoer. Going to Switzerland he lectured at Bale (Basel) in his broad German-Swiss dialect and his discourse was often illustrated with off-color stories. Nevertheless he attracted crowds to his classes where he taught that Galen was wrong. He was one of the first to ask that medical practice be based on experiment and observation not forgetting however, the real knowledge of the past. For his criticism of the medical profession and the druggist he was hauled into court and found guilty. However he escaped before the police could find him and returned to Austria. Paracelsus was among the first to follow the teachings of Theodosius of Cervia who in the thirteenth century taught that pus was not necessary in the healing of wounds. The next man in medical history of any importance was Lister. Paracelsus lived fighting his way. How he died we do not know. His bones rest behind his picture in the church in Salzburg. The inscription gives him among other titles that of Doctor of Medicine. On the outside of a building in the center of the town now used as a drug store, which is rather appropriate is a plaque with an inscription giving the information that Paracelsus lived in the house. Paracelsus, or to give his full name, Phillippus Aureolus Theophrastus Paracelsus Bombastus Hohenheim, was a most interesting character. His life is well worth reading. A great deal of a quack delving into all sorts of things, he added substantially to the medical knowledge of his time. Salzburg is a town where much can be seen without great effort as it was formerly a walled city and the principal sights were within the line of the old walls. There are many large restaurants in Salzburg. In the Stiftkeller (rather suggestive name) near St. Peter's church and graveyard—Hayden, the composer spent his evenings with musical friends. One can visit fine museums, see great churches built by the Bishop Princes and besides listen to fine music as provided by the Festspiel. Seeing "Yederman" the old morality play of von Hofmansthal with Moissi in the star part—Fidelis and other operas and music adapted by Mozart. In the cathedral the masses of Beethoven played by the organist Sauer and Wessen. The person to whom music has a strong appeal can easily spend a week here.

### GOTHENBURG, SWEDEN

We left New York by the Motorship Gufsholm and landed in Gothenburg nine days later. Here one finds excellent hospitals, some very interesting museums with rooms furnished in different periods to illustrate the way people lived. There is the University College and the Chalmers Technical Institute. Gothenburg reminds one very much of Holland because of its many canals. In fact it was laid first by Hollanders. The historical side of the city shows that it was founded by King Gustavus Adolphus "The Lion of the North" and the champion of Protestanism" about 1619. A recent number of the London Times announced that one section of the great Vatican library at Rome was the gift of Queen Christiani, daughter of Gustavus Adolphus, who abdicated the throne and embraced Catholicism.

About 17 miles from Gothenburg is Floda near Lake Savilange; here on the Naas estate is the famous Sloyd Seminary founded in 1874 by Angus Abrahamsen a citizen of Gothenburg. Students come from all over the world to study the methods in manual training which were devised by the Swedes and now used everywhere. Gothenburg has two fine botanical gardens, the old one, Tradgardsforeninger, being right in the center of the city where one may see the plants and flowers and also listen to good music during refreshments.

### GOTA CANAL

From Gothenburg to Stockholm runs the Gota canal through the center of Sweden. One gets into a little boat and goes up to the woods and down to the sea again. The steamer sails along the Gota river and comes to Trollhattan Falls where

there are large hydro-electric stations, at the side of which one can see the rapids from which comes the power. Here we took a long walk while the steamer went through a regular stairway of locks. Then we passed to Lake Vanern which is a small inland sea and out of it by a series of locks until we were 300 feet above sea level—enter another narrow river, so narrow that one can touch the branches of the trees. Then one comes to Lake Vattern, here we stop for a short time at Vadstena with memories of St. Bridget, Sweden's most distinguished national figure of the fourteenth century, founder of the Order of St. Bridget with its hospitals and nurses. From Vadstena we continued to Motola and come to Berg with its 15 locks and change for another good walk. Then through the many islands of the Baltic Archipelago the little boat enters its last canal called Sodertalje cut out of the rock and then passing the islands great and small of Lake Malaren we come to Stockholm. The trip takes two and a half days and is the best way to get an idea of the country. Sweden is an easy country in which to travel. The study of English is compulsory in the schools. I never hesitated to ask questions because upon trying I found that the person addressed would nearly always reply in my own tongue. For a coffee drinker like myself I must say that the Swedish people know how to make good coffee. The Swedes are a very democratic people and as far as I could judge have the same outlook on life as we do. Of all the people in Europe they use the telephone the most. They love music and pictures and home comforts. I saw many copies of American music in the windows, also phonograph records. The Swedes are a very likeable as well as substantial people who have been a source of strength to our own country. In fact there is shortly to be a celebration of the three hundredth anniversary of the first permanent Swedish settlement in America. They have been among the best supporters of our American institutions. We have in our own city of Detroit about 20,000 Swedes. In the upper peninsula are many people from the northlands who have been the pioneers in developing the resources of a land which resembles their own in many respects.

### SMORGASBORD

Just a word about Swedish meals. One begins his meals with a collection of food with the above title. An ennumeration of the dishes one day showed 25 articles; three kinds of bread, two varieties of cheese, unsalted butter, omelette of mushrooms, dill pickles, radishes, beets, cucumbers, four kinds of salted fish, fried kidney, salmon in jelly, sardines, boiled potatoes, cold veal, ham, tomatoes, lettuce, head cheese, shrimps. One helps himself to what he likes and eats it before his regular meal which consists of veal and potatoes, fish, dessert and drinks. It is a fearful and wonderful experience the first time but one soon gets used to it and follows the old saying "when in Rome do as the Romans do."

### STOCKHOLM

Stockholm is a delightful city modern and up-to-date with its many fine buildings. It is the capitol of Sweden, the residence of the court and seat of the Rigsdag or Parliament. The city hall, a masterpiece in brick, is one of the finest buildings in Europe and is not only a delight to the eye but has many fine rooms to visit. One of the great halls is furnished in Mosaics in which the countries of the world are depicted. The United States has the American flag, an American Indian, skyscrapers, etc. Stockholm has its university with a fine medical department. Thanks to my friend Dr. B. H. Larsson who gave me a letter of advice, I was enabled to get about and see things.

### SERAFIMER LASARETTET

First to the Serafimer Lasarettet, this means hospital, where Professor Gosta Forsell, professor of X-ray and Radiology, has a fine clinic. Professor Forsell was absent, being in Amsterdam attending an International Medical Meeting and his chief assistant showed me through the hospital which is old in type but doing good work especially along X-ray lines, of which Professor Forsell is one of the leaders. Plans are being made for a new institution. In the professor's room the walls were covered with photographs of X-ray men from all over the world and among them I saw the faces of Doctors William Evans and Rollin Stevens of Detroit. This struck me as a very nice idea, all these photos of fellow workers with words of appreciation.

While walking through the hospital we met Dr. Israel Holmgren who is professor of the Faculty of Medicine, University of Stockholm, administrator of the hospital and member of the Swedish Senate. Later I found he is the editor of the Archives of Medicine and well known through Europe and America for his medical work.

He speaks English so well that he can joke in it, which gives an idea of his ability along that line and of course speaks French and German. The European doctors are linguists and scholars besides being physicians. Under Dr. Holmgren's guidance I saw the wards, no private rooms, in fact his own private patients have to be accommodated in wards if they desire to enter the hospital. This will be remedied in the new institution. Learning by a chance remark that medical history was of interest to me, he took me over to his home nearby in the hospital grounds, and here was spent one of the most pleasing hours of my trip. His library is a real workshop, books lining the walls to the ceiling, American, English, French, German and Scandanavian. The room was furnished with oil paintings, easy chairs, a desk piled high with work, the typical work-room of a busy man. He showed me his fine collection of old medical books. There was a small book on American History presented to his grandfather bearing the signature of Benjamin Franklin on the title page. Here was given one the privilege of seeing the inside of a Swedish home which is quite different from ours. The doctor has a sound-proof room on the top floor of his home where he can retire and rest secure from interruptions. All in all Dr. Holmgren is a delightful man whom I consider it was a privilege to meet.

### RESTAURANTS

Leaving the hospital I gathered the family and went to lunch at "Den Gyldene Freden" or "The Golden Peace" an old and famous cellar restaurant where there is excellent food and drink at moderate prices. Don't miss this place or the "Rosebad," Cafe Opera and others and don't forget to have delicious coffee and the best of cakes at any of the numerous "conditeri."

It might be of interest to say here a few words about tips. In Swedish hotels and restaurants the tip to waiters is 10 per cent of the bill. The hotel servants 15 per cent divided among the "Portier" chambermaids and hotel porters.

### "THE SCIENTIFIC CITY"

Outside Stockholm about 30 minutes by electric train at the station called Frascati, after the town in Italy, is situated the new scientific city. Here are seen the really magnificent buildings of the "Swedish State Museum of Natural History," National Academy of Science, the Nobel Institute, the School of Forestry, the Veterinary school and a very fine botanical garden. The place is still in its infancy and one is impressed with the great work going on in the small countries. Sweden has always been noted for its scientific spirit in all lines.

### NORTHERN MUSEUMS

Stockholm possesses some excellent museums. The Northern museum with its great collections of antiquities and other objects relating to the history of Sweden is a place to visit again and again. Here you find rooms furnished in the various periods from the earliest times onward so that it is possible to visualize the life of the people as in no other way. Models of all sorts abound. Nowhere else in the world can Scandanavian life be better studied. Nearby is the biological museum housed in a wooden building somewhat after the style of the old Stave church. Here one can study the animal life of Sweden, 12 sections illustrating the different divisions of Sweden.

### SKANSEN

A short walk and one comes to Skansen which is called the greatest outdoor museum in the world. Here are gathered buildings of all kinds, churches, farm houses, Lapp homes, dwellings, from all over Sweden one may enter and see how the Lapp lives; the peasant of olden times, the farmer, cheese maker, the church they worshipped in may be seen. Performers in the natural dress do the old time dances to the music of old Sweden. When one tires of this there is a fine open air restaurant where one may refresh himself while listening to the music of a good military band. The waitresses all dress in the peasant style. This is one of the sights that must not be missed.

### MARIA SJUKUS HOSPITAL

I saw several operations at this hospital and through the courtesy of Dr. Hellstrom was shown the hospital, an old time place but up to date in the work. In the operating rooms the men were wearing dull green gowns and the patients were covered with the same sort of sheets. The reason for using green is because it is easier on the eyes, same principle as green tile and green paint in our own operating rooms. Much local and rectal anaesthesia here as in Berlin, Vienna and Budapest.

"DR. IVAN BRATT AND THE STOCKHOLM SYSTEM OF ALCOHOLIC CONTROL"

As the question of prohibition and alcoholic control is one of the main topics of conversation daily in the United States a few words regarding the system used in Sweden will be of interest. Accordingly a visit was made to Dr. Ivan Bratt, originator of the Stockholm System, or as it is now called the Bratt System. Dr. Bratt was educated and practised as a physician in Stockholm before giving up his whole time to the system. He speaks English fluently and has a decidedly pleasant manner and one instantly feels he is in the presence of a man with a great idea, fully capable of carrying it out. In brief the Stockholm System is a form of monopoly whereby a private corporation controls the manufacture of alcohol in Sweden as well as importation of all forms of alcohol. The corporation can only make 5% on its investment and the control is in the hands of a group consisting of five from the company and five from the government, all profit over 5% goes to the government. This corporation supplies to companies of which there is one in each of the various districts of Sweden with liquors. To obtain wines, brandies, whiskies or in fact any known form of alcoholic beverage one must obtain from the main office a book. Before getting the book one must give his life's history, amount he pays in taxes, whether you have ever been arrested for being drunk, inform the company of the quantity of intoxicants one thinks he requires for ordinary purposes. The company then investigates to see if the applicant is 21 years of age, whether he has ever been found guilty of drunkenness or certain crimes more than once. If the applicant is found guilty he is out of luck. If the applicant is satisfactory a pass book is issued. (It is said that there have been more copies of this book published than any other in Sweden.) This book tells how much one can buy a month. Men under 25 years of age do not readily obtain books and particular attention is given to issuing books to women. Under the Bratt System in hotels and restaurants you have the following units:

Spirits. No wines or spirits are served before 9 o'clock or during hours of divine service.

Intoxicating liquors. May not be served before noon, and after that hour with certain restrictions only to a guest having a meal.

Hot wines are served only to persons having meals and subject to certain restrictions, also to guests taking light refreshments such as pastry, fruits, etc.

Light wines and light drinks may be served before 15 o'clock weekdays and 19 o'clock Sundays in connection with meals, and are after that hour free of restriction.

After midnight no wines and spirits are served and guests are not admitted to restaurants after that time.

There is no temptation for the proprietor of a restaurant to sell you more liquor because he buys all his supply from the company and if his total sales rise above a certain maximum he is deprived of his profits and sometimes of his right to purchase. What are the results? I have only imperfectly given a few high lights in the system which is now 10 years old. Statistics are as follows:

1913 Sentences for drunkenness was 10 per cent per 1,000—all Sweden.

1923 Sentences for drunkenness was 5 per cent per 1,000—all Sweden.

1913 Sentences for drunkenness was 41 per cent per 1,000—all Stockholm.

1923 Sentences for drunkenness was 18 per cent per 1,000—all Stockholm.

1913 Alcoholics admitted to Central hospital, 584.

1923 Alcoholics admitted to Central hospital, 211.

It is to be regretted that lately there has been trouble due to smuggling of spirits into Sweden from Germany and Eusthonia. Of course it is difficult to predict the results of the system. Dr. Bratt has repeatedly said that it is an experiment that must be judged by its results. To what extent it can be applied to other countries can naturally not be determined beforehand and its originator has never dreamed it can be made an article of export. Dr. Bratt says that the only article he has written in English appeared in Harper's magazine for May 1923. There are two pamphlets in English, "The Swedish Alcohol System," by M. Marcus and "The Alcoholic Question in Sweden," by Einan Rosenberg which explains the system more fully.

Stockholm is a city that one easily learns to like, the people are cordial, much English is spoken, there are many excursions to be made by tram, train, and the little white boats will take you out into the Archipelago for which Stockholm is famous. All sorts of boating, fishing, and with it good food and drink at most reasonable prices.

VISBY

From Stockholm we went for a visit to the ancient city of Visby in the Island of Gotland out in the Baltic. This city of Roses and Ruins is one of the few places in Europe where the city walls are still

complete. The town has many churches, ruins of an old hospital and a history that is appealing in its melancholy. Well worth a visit by the lover of ancient things. Once it was a great commercial city, one of the Hanseatic League; in fact, for a time it was the headquarters. In those days Visby was the opposite of what the travellers see today. The riches that flowed here were expressed by the poet in these words:

*"The Gotlanders weigh gold with twenty-weights,*
*And play with the choicest gems,*
*The pigs eat out of silver troughs,*
*And the women spin with golden distaffs."*

But those days are gone forever, only the sleepy little town greets you.

UPPSALA

Another trip was made to the old city of Uppsala with its university the oldest and largest in Sweden celebrating its 450th anniversary this year, and the cathedral also the largest in Sweden. In this church are buried Gustav Vasa and his three wives, Swedenborg, the mystic, and of interest to medical men Carl Von Linne of which more later. Up in the hill is a great barn of a castle, scene of the abduction of Queen Christianna in 1654. The university buildings are scattered about the town but are in excellent condition. The Museum was formerly the anatomical laboratory of Rudbeck. His statue is now in front of the histological laboratory which is well filled with specimens. Rudbeck described the intestinal lymphatics and their connection with the thoracic duct. Below the castle is a beautiful botanical garden with its university building of the Classic temple style. This garden replaces the Linneaus Botanical Garden, which however is still preserved. The garden was originally founded by Olof Rudbeck, the Elder, in 1655 and became famous through the work of Linne. The library is large and has many famous books, among them the "Codex Argentus." The University hospital situated on a slope at the edge of the town is one of the finest I have visited, with its double doors, large rooms, sitting rooms for patients on each floor, fine offices for the attending physicians, up-to-date operating rooms, kitchens and baths. On the wall of the ante room of the operating department presided over by Prof. Gunnar Nystrom is a picture of Dr. William Mayo.

OLD UPPSALA

A short distance from Uppsala is "Old Uppsala" the cradle of the Swedish King-

Swedish kings and the center of pagan worship in the north. Now all that is left dom and in olden times the seat of the is the three mounds of earth which are said to be the graves of three kings of old, about the sixth century. Some question this however.

LINNE'S HAMMARBY

After visiting Uppsala I made a little pilgrimage to the old home of Linne, "The Father of Botany." This was done in a well known car manufactured in my native city of Detroit. Here in this shrine of botany in days gone by students from all over Europe and even America came to sit at the feet of the master. Linne was a doctor of medicine, his degree being obtained in Holland. It is said that in his early days as a physician he was much in demand by the young men of Stockholm for his skill in treating certain special diseases of youth. Another story is to the effect that he studied medicine so as to marry a wealthy doctor's daughter. Linnaeus was the first to give a concise description of plants and animals and originated the idea of classifying each definite natural object by a generic or family name. Among his works are "Systema Natural (1735) Materia Medica (1749) and his scheme of Nosology (Genera Morboran 1763). He is said to have given good descriptions of embolism, hemicrania and aphasia (1742) "Garrison." The estate is about six miles from Uppsala and was purchased by Linne in 1758 and used by him for 20 years as a summer residence. He had a "museum" on the top of the hill, there are still foreign plants growing that were planted by him. In this little museum building he had his herbarium and other collections and here he lectured to the students. The chair in which he sat and the three wooden benches are still there. The students lived in the farmhouses round about while attending his lectures. The collection made by Linne was sold after the death of his son in 1783 to the English botanist J. E. Smith and is in London at Burlington house under the care of the London Linnean society. The estate consists of three buildings, the main building with two wings, the eastern and western. The estate is now owned by the state and is known as the "Linnean Institute at Hammarby." In the main building are many relics of Linne including the bed in which he died, above the door leading into the bedroom is painted Linne's motto "Innocue Vivito, Numen

Adest" "Live innocently, God is near." The parlour is unique because of its papering which consists of prints from J. Burmann's work on Plumer's American Plants published in 1755-60. The eastern wing is only used for purposes connected with the estate. The western wing houses a collection of reproductions of Linne's portraits, monuments, clippings, casts, etc. So back by the Ford and thence to Stockholm after my little visit to the home of Linne, the great botanist, who was also a physician.

DALECARLIA

From Stockholm we went to Dalecarlia to the town of Rattvik called the "Eye of Dalecarlia. Here it was that Gustavus Vasa called his countrymen to arms. In the old churchyard is a monument to commemorate the occasion and here one Sunday we see the people in their native costumes entering the church. Round about the church are little wooden cabins where the people put their horses while at church. Surely a human thing to do in the cold weather. These are not used as much in these days of motors. It was an interesting ride to Leksand where there is a church holding 5,000 people and believe me it was well filled with worshippers who lifted their voices right lustily in the singing of hymns. It would take a woman to describe the various outfits worn by the people. At Mora nearby is the home of the great painter Zorn, who recently died. We leave Dalecarlia with regret and now through increasingly beautiful scenery we come to the land where like in the northern part of Sweden the sun never seems to set. At 11 p. m. it is still light and at 2 p. m. it is morning again. It recalls to the mind the lines of Edmund Gosse:

*"There is no night time in the northern summer,*
*But golden shimmer fills the hours of sleep,*
*And sunset fades not, till the bright new comer,*
*Red sunrise, smites the deep."*

NORWAY

Oslo, formerly Christiana, the largest city and capital of Norway is situated in a fjord called by the name of Oslofjord. Here we took an auto and rode along the principal street called Johnsgate at one end of which is the Royal Castle. Up to the top of Ekeberk hill where there is a fine view of the city; then through the old town and passed the park called Hauskanger to Holmenkollen for another magnificent view. Here we pass Konsgaarden, the summer home of the royal family. Nearby is a fine people's museum known as Bygdo with its open air section devoted to original old farm houses, furniture, etc. from various parts of Norway. Here we see the Gol Stavkirke, an old wooden church built in the twelfth century brought here in 1885 from Gol, in the district of Hallingdal. On the way back we stopped to see the famous Oseberg Viking ship. Other sights of interest are the university, national theater, and other public buildings.

OSLO, NORWAY

The medical department is a part of the King Friederich university. The number of medical students is limited by law. I had a long talk with Dr. Charles M. F. Sinding-Larsen, Direktor, Rikshospitalet, which being translated means State University hospital. He was busy with plans for a new institution and from the looks of them it would be the last word in hospital construction. In this city hospital and in all the state institutions the price per day for a patient is three Swedish Kroner, about 75 cents a day. Besides the clinics and hospitals in the city there is a great city hospital on the outskirts of the town and about 40 miles away is the great Municipal Tuberculosis Sanitarium. One also goes to see the old Viking ships with their thousand year history and the museum with its relics of Viking days. America is especially interested in the story of Leif Ericson who it is said discovered America 900 years go.

WOMAN'S HOSPITAL

The Kvindekliniken or Woman's and Babes Clinic is a fine modern building especially equipped for obstetrics. The chief is Dr. Kr. Brandt, one of the leaders along this line in Scandanavia. His first assistant Dr. Kr. Skajaa very kindly showed me through the hospital. Price here even for obstetric cases is three Krones per day. There is published at Helsingfor a journal devoted to obstetrics and gynecology called "Acta Obstetricia et Gynecologia Scandinavica." The hospital averages between 1,500 and 2,000 obstetric cases a year, 85 per cent spontaneous and no narcosis used. Thirty Caesarean a year, they wait a long time before using forceps, depending on action of fetal heart or whether case is clean or infected. Eclampsia is treated by venesection and the Stroganoff method. Hospital period 14 days. There is very little G. C. infection. There is a well conducted school for mid-

wives, course is one year and costs 300 Kroner. Afterwards they are sent to country districts and earn about 3,500 Kroner a year. One Kroner equals about 26 cents in American money.

NORWAY

Norway has more wonderful scenery in a small compass than any other country in Europe. In three hours' auto ride you may have all the seasons of the year. We went from Oslo to Myrdal and through the wild Flaan Valley to Sognefjorden, snowball battle in July, down to the fjords thenc to Stalheim with one of the most glorious and impressive views in the world and one of the finest hotels in Europe. Then on to Ulvik via Voss by motor, next day to Breiforin via Utnia to Odda where the pass goes up the mountains between banks of snow, a desolate country. Breiforin to Nesflaten to Dalen through this Telemarken to Skien and back to Oslo. You make your way by boat, train, auto, walk and then ride in a curious two wheeled mountain carriage called a "stolkjaerre." It is a land that knows no night, the land of a thousand waterfalls, of picturesque valleys and snowclad mountains, glorious sunsets. For the hiker wonderful climbs, for the motorists good roads. Excellent country hotels, the like of which I never saw before, prices are exactly the same in all of them. One can make any kind of a trip he wants and find good accommodations. Norway is a paradise for fishermen and hunters. But we must leave this land of scenic delight.

DENMARK

From Oslo we went by train southward to Denmark and its capital Copenhagen. Denmark is called "The Country of the Sea" as it is almost surrounded by water. There is no other country in Europe with such an abundance of islands and peninsulas, the same constant changing of sea and land, of straits and channels, of bays and fjords.

COPENHAGEN

The capital, Copenhagen, has been termed by some "The Athens of the North." It is an old city with an interesting history, very important business center busiest port of Denmark. We liked Copenhagen very much, there is a sort of cosmopolitan aspect that appeals to all. Of interest to the tourists are the renaissance buildings like the Exchange with its queer green dragon spire that makes us think of the Far East, the beautiful little palace of Rosenberg with its great collection of art treasures, Thorwaldsen's museum, in the couryard is buried this great and good man; the national gallery and the wonderful Carlsberg Glyptotek. The Town Hall is also very fine in a modern way.

"FINSEN INSTITUTE"

When one thinks of Copenhagen in a medical way there is always one figure that stands out and that is Niels Finsen, the pioneer in light therapy, the "Institut Phototherapique. Finsen was the first place visited. Here I was shown about by the Chief of the Clinic Dr. Svend Lomholt. The institute is now in its twenty-fifth year and consists of five departments so that all the various departments of medicine are covered. There is a staff of about 260 people employed. The situation is a pleasant one with gardens between the buildings. The large room in which some 30 or 40 people were undergoing treatment with the Finsen lights mostly for lupus or tuberculosis of the face and extremities, is a unique sight. There are other rooms where the individuals, stark naked, are get ting the arclight treatment for tuberculosis. It is a busy place. The records have attached photos showing the skin lesion in the beginning and then at the end of treatment. It is truly the world center for the treatment of any diseased condition in which light, radium or X-ray treatment is indicated.

TIVOLI

No visitor to Copenhagen should miss the great amusement park called Tivoli, with its fine bands, outdoor restaurants and amusements of all kinds. Situated in the center of Copenhagen, it is in a class by itself.

"ELSINORE"

And always to the lover of Shakespeare will come the thoughts of that most quoted of his plays "Hamlet" for it is in Denmark at Elsinore (Helsingor) that the scene of Hamlet is laid. We made a trip to this lovely spot to visit the grass-covered ramparts of Kronborg Castle, which guard the strait, this old sentry of the Baltic, where they point out to you the spot where the ghost of Hamlet's father appeared. If you will believe it you may see near by in a beautiful park what is said to be the grave of Hamlet. Elsinore is a picturesque and interesting old place. It was in Hamlet that Shakespeare tells us that:

*"Our wills and fates do so contrary run*
*"That our devices still are overthrown."*

One can combine with this trip a visit to

Fredericksberg Castle with its wonderful national collection. The history of Denmark has always been closely connected in past centuries with that of England especially in the days when Denmark was mistress of the north. How times change and nations also. There is also on the way the Fredensborg Slot with its rather plain buildings but wonderful gardens where in the days before the great war the nobility of Europe were wont to go and rest from the formalities of court life. There is much to be seen in this little country with its memories of Hamlet and our childhood days, Hans Christian Anderson, who was a Dane. We must hasten on to the next step of our journey.

### BERLIN

In our travels we have visited Vienna, Buda-Pesth, Oslo, Copenhagen, Stockholm and Prague but in Berlin we found the greatest activity; business seems to be humming; shops filled with goods; the great department stores like Wertheims filled; theaters, cabarets, beer halls, restaurants and coffee houses are doing capacity business. One day we had lunch at Tempelhofer Field in the suburbs of Berlin. This is also a busy place with planes coming from all parts of Europe with a railway schedule.

### KAISERIN FREDERICK INSTITUTE

To the medical man who speaks German, Berlin is a fine place to go about visiting hospitals and clinics. To help the foreign physician seeking post-graduate work in Berlin there has been established the "International Medical Post-graduate Courses." These courses are conducted by a union of professors and by an organization centered in Kaiserin Frederick Institute with the assistance of the medical faculty of the University of Berlin. Externships in clinics and hosiptals and laboratories are also provided. The courses listed are intended for foreign physicians who intend to stay in Berlin for more than a month for the purpose of specializing thoroughly in a certain branch of medicine. Practical courses are given in German and English. The office is, Kaiserin Frederick Haus, 2-4 Luiseuplatz, Berlin, N. W. 6.

The director in charge is Professor Dr. C. Adam, a very pleasant gentleman, who will be glad to give any information desired. Courses are on a monthly basis and includes under the price the rate for several persons. The rate for several persons, one person only costs 50 per cent more. Rooms may be had in flats and hotels. Rates in hotels from 8-10 R.M., that is, $1.50 to $2.00 per day. Private rooms, 50-100 R.M. a month. Rooms can be arranged through the office. Courses at present cover Pathological Anatomy, Pathology, Bacteriology, Sociology, Physical Chemistry, Internal Medicine, with practical work in Laboratory, Roentgen Treatment, Neurology and Psychiatry, Pediatrics, Surgery, including Orthopedics, Gynecology and Obstetrics, Forensic and Social Medicine. Rates vary from 10-20 R.M. per hour and also by private arrangement. Most of the courses average 200-250 R.M. per month. R.M. equals 24 cents in American money.

### HOSPITALS AND CLINICS

Among the great hospitals a visit was made to the "Charite", where several lectures were heard in wonderfully equipped amphitheatres with lanterns, blackboards, laboratory equipment, X-ray stands, skylights worked by electricity, so that the room could be completely darkened. Patients were examined very thoroughly and as a rule only one or two patients are used during the demonstration. Students are called down to examine cases and be quizzed. There are many women studying medicine in Berlin and Vienna. In the entrance hall to the Pathological building is a marble bust of Virchow and in one room are relics of this great man. The museum itself is vast and, of course, especially rich in specimens relating to tuberculosis, cancer and syphilis. The number of specimens are such that one can study the effects of these diseases and others on any part of the human body. Another day a visit was made to the Surgical Clinic of the great German surgeon, Bier. The Clinic is held in one of the old amphitheatres and is one of the old type, the master surrounded by his faithful staff and the crowded rows of students looking down, really makes a wonderful picture. In this part of the theatre is a bust of John Dieffenbach, 1840-1847. John Frederick Dieffenbach was one of the greatest of German surgeons and made many advances along this line. He was a soldier in the German war for Independence, was noted for his ability as a teacher. He said that the surgeon should be a many-sided individual, be a clear thinker and a good writer. As a man he was beloved for his many engaging qualities and this explains why his bust is in the Bier Clinic. This was a general surgical clinic, several fracture

cases, diagnosis of jaundice from cancer, stone in right ureter, tumor of the neck, atrophy of the muscles, diagnosis from malignancy (young girl) and lastly, operation for large abdominal hernia. The operator wears wooden shoes, no gloves, "Bier says he is not afraid of infection in a clean case", wear face masks attached to eye glasses, crowds of assistants, students called down to examine cases and be quizzed. Bier is a fine teacher and has a great personality, very pleasant to meet. Rectal anaesthesia is used a great deal and a new one, called "Averten", said to be a combination of ether and bromide, is being tried. It is a secret preparation and still in the experimental stage, as in the hernia case, not always successful. In Germany medical students go from one university to another during their course of study. In this way they are enabled to get a training that is rather different from the one that is usually carried out in our country. To my mind it has some very definite advantages.

It is best not to be in Berlin during the months of August and September, as these are the vacation months for the big men. Berlin has so many hospitals and museums that one can spend any amount of time going about. Of course, there are other attractions such as the museums of art and sciences, the Royal Library, opera, theatres, and all the historical monuments to be seen. It is good to see the monuments to medical men like Virchow and, in the Charite, busts of Traube, Orth, Allhoff, and others. Would that more of this was done in the world to remember the great men of medicine who have done so much for humanity to save life and not destroy it, as witness the statues to military heroes.

To the German-reading physicians who desire information relating to all the medical activities in Berlin, I refer them to Die Medizinschen Fortbildungskurse und Einrichhingen Berlin, published by Oscar Rothacker (Urban and Schwarzenburg), Berlin, N. 24, Freidrichstrake, 105 B., for October, 1927.

Berlin on the Spree is surely getting ready for giving post-graduate work to the Ausslander.

### DRESDEN

From Berlin we went to Dresden, the capital of Saxony, on the banks of the Elbe. This is a most satisfactory town to visit and casts a spell over most visitors, especially those interested in Art. It is called the Florence of Germany. This year there was a most interesting exposition devoted to "Paper". One never realizes all the uses paper is put to until he sees an exhibit like this, everything from a fan to a locomotive wheel. Nearly every city in Germany has an exhibition of some sort during the year and they are worth seeing. The great treasure in art is the famous "Madonna di San Sisto" by Raphael. In the Green vault one sees a fine collection of man's ingenuity and among them the celebrated "Court of the Grand Mogul", with its 132 figures all made out of pure gold. One of the finest collections of arms and armour I ever saw are in the Museum Johanneuss. There are many beautiful parks, churches and notable buildings. One can go by motor to Meissen to see the Royal Porcelain manufacturing which, by the way, was the first place in Europe where porcelain was manufactured in 1710. The region round about, known as the Saxon Switzerland, provides many trips of interest.

### PRAHA

Praha, or as we say in English, Prague, the capital of the old kingdom of Bohemia, and now the capital of that patchwork of nations known as Czechoslovakia, compound of Bohemia, Moravia, part of Silesia, Slovakia and Carpathian Ruthenia, a state made up by the League of Nations after the strenuous work of Masaryk. President Thomas Garrique Masaryk is one of the most talked about men in Europe and many people are of the opinion that it was entirely due to his efforts that we have the republic of Czechoslovakia. His life story is a most romantic one. Before the war he was known principally as a writer and philosopher. As a politician he is vastly different from our popular conception. Essentially a religious man, it is said that his motto is "Jesus, not Caesar", which does not sound like the slogans used in this country. His life is well worth reading. Czechoslovakia has been called a land of spas and woods and is well called. Here we find the famous spas of Karlovy Vara (Karlsbad), Marianske Lazire, (Marienbad), Frantiskovy Lazue (Frauzenbad), Jackymov (Joachmsthal). This is the state owned radio-active spa, and the queer island of mud, called Piestany, where you can see a whole museum of crutches of patients who have been cured there. At Podebrady there is an up-to-date research institute and hospital for heart disease. In all of Europe

it would be hard to find such an array of springs with the one exception of Budapest. The Czechoslovak State railroad grants to all visitors to spas or health resorts a 50 per cent reduction in the price of railroad tickets for the return journey, the only condition attached is that ten days be spent at one of the places.

PRAGUE

Prague is situated on the River Vltava and is one of the oldest o fthe European cities famous for its art, architecture and rare historical monuments. Among the sights we mention the Castle of Prague, the old Jewish Cemetery and Synagogue, the little Chapel where John Hus preached, the abode of Mozart, the old university founded by Charles IV in 1348, the great Cathedral of St. Vitus, dating from the fourteenth century, the old bridge across the river, and the many monuments; in fact, from a historical standpoint there is much to see. At present the city of Prague on its main streets resemble an American city as the streets are torn up and much work is being done in this city of the new republic. Someone has dubbed the Czechs as the "Yankees" of Europe. By the activities in the street it would seem so.

KARLSBAD

I made a trip to Karlsbad, "The Queen of European Spas", as Karlsbad is called, where it is said over 70,000 visitors and 200,000 tourists gather during the season from all countries of the world. The medicinal qualities of its hot springs and baths are said to be unrivalled. Here are found general practitioners and specialists speaking almost every language, to look after the welfare of the visitors. In the summer it is very hot and dusty in Karlsbad and apparently not so crowded. It is interesting to see the people going to these springs with their glasses and solemnly drinking the prescribed amounts at periods of the day. At the noon hour music is provided and the people promenade back and forth.

Prague has its university and medical department. The hospitals are situated on the edge of the city with the university buildings scattered about. Owing to the language difficulty and because the summer vacation was on I was unable to get any very definite information regarding medical work in Prague. So we left Prague and went to the Mecca of all good American post-graduate seekers.

VIENNA

If one may judge by the activity about the A. M. A. headquarters, there is no let-up in those who go for post-graduate work in Vienna. To the old-timers it may be news that the Cafe Zur Klinik at the corner of Lazarettgasse and Spitalgasse is no longer the place of meeting of the doctors in Vienna. It is now the club rooms of the Egyptian students. The new address of the A. M. A. is the Cafe Edison, Alser strasse 9, Vienna, VIII, where, on the second floor there is much more room. The work is now being taken care of by two men in the office with the assistance of various orientation men. The place is as busy as a beehive with American doctors, black and white, male and female, who are coming and going, eating and chatting and consulting the cards which give the various courses. The prices have advanced over two years ago, when membership was $5.00 to $14.00. Ten dollars for membership (life), one dollar a month dues, and three dollars for a year's subscription to "Ars Medica", the journal of the A. M. A. of Vienna, published in English and giving a review and abstracts of foreign (especially Viennese and German) medical literature. It is an international exchange of opinion, a small journal, but interesting on account of the information it gives in regard to the latest work in Vienna. To the intending visitor it will save time and money if he will write to the A. M. A. at the address given for a copy of the "Blue Book". Here he will find a history of the organization, the aims and purposes, list of members, professors giving courses, list of courses, in fact, all the information necessary in order to take up post-graduate work in Vienna. In the A. M. A. headquarters he will meet with people who speak English and have the whole machinery oiled for his benefit, provided he has the necessary funds. For those who are familiar with German there are the courses given by the University of Vienna. Copies of the catalogue of the university in German entitled, "Verzeichnis der offentlichen Vorlesungen and der Wiener Universtat in winter and sommersemester and Verzeichnus der Ferialkurse" can be obtained by sending 25 cents in American money or English stamps, to Wilhelm Maucrich, Spitalgarse, 1 b. Wien IX, also of interest to readers of German is a new book entitled "Das Medizinische Wien", von Dr. J| Friedmann. Cost, Austrian shillings, 4.25-6. Shilling is approximately 14 cents. This book can also be

obtained from the same address given above. It is illustrated and is a mine of information. The author says in his preface: "First and foremost, this book is written for the benefit of the medical profession. The writer has had special opportunities for observing American physicians doing work in Vienna and as a result of his observations he writes this little book, 'Medical Vienna.' He says that the book is to be translated into English" (I hope so) "and is for the purpose of aiding medical work and to be of benefit to medical visitors in Vienna. The medical life of Vienna is manifold and far-reaching and is always advancing and new discoveries are being made in the great work of medicine. Not only the strangers, but the doctors of Vienna can find something new and worth while in the medical work done in Vienna." With the "Blue Book" of the A. M. A. and the two books mentioned above you will have a complete guide to all the post-graduate work and in fact all the medical work done in the great medical centre.

Vienna has much to interest one in its great museums, not only of art and science but of Anatomy, Pathology, Medical History, etc. "All work and no play makes Jack a dull boy." In Vienna you may get all the work your heart desires and have play, too. What one gets out of post-graduate work in foreign cities depends upon the individual and his knowledge of the language. If one has the time, there is an excellent organization called "The Austro-American Institute of Education", which is under the patronage of the president of the Austrian republic, Michael Hainisch, and has an honorary president, Albert H. Washburn, American minister to Austria, and others. Headquarters are Vienna 1. Elizastrasse g. The aim of the institute is to be an educational centre, while at the same time being of service to American visitors in all the practical necessities of life connected with their stay in Vienna. To give an idea of the scope of work one can take:

1. Language courses at the University of Vienna.
2. Culture courses in English or German.
3. Conducted tours to schools, libraries, castles, art galleries, etc.
4. Also a seminary for American teachers along the same lines with special reference to teaching of Art by the Cizek method.

The Institute will quote a rate from United States to Austria for a week, a month, or longer course in Vienna. The rates are most reasonable. You may take a lecture, a day's work, one week, or the entire course. For example, Dr. Frederick Hertz, "Economic Conditions in Austria"; Dr. Alfred Adler, "The Principles of Individual Psychology"; Dr. Clement Pirquet, "The Vienna Medical School", etc.

Around the courtyard of the university are placed in the walls busts of the teachers and I was surprised to find that nearly a fourth of the members were medical men. Names and busts of Billroth, Kraft-Ebbing, Rokitansky, Hebra Skoda and others, Hyrtl, Hoopler, Nothnagel. In the book stores you may get for your library not only books, but pictures relating to medicine like "Der Artz", by J. Salinger; "Christ als Arzt", by Gabried Max; "Rembrandt's Study in Anatomy"; John Steen, "Kie Kranke and der Arzt"; "Der Arzt", by Rozynsky, and others. An illustrated pamphlet entitled, "Kunstablatten fur das warte and Sprechzimmer des Arztes" can be obtained free of charge from the same man who has the medical books for sale mentioned above.

And so "Aufuedersehn" to Vienna with all its delights even in its days of strife and in two hours by air we were in Buda-Pesth.

BUDA-PESTH

My first air voyage was from Vienna to Buda-Pesth. It consumed two hours and was great experience. As soon as possible I taxied to the Hotel St. Gellert said to be the headquarters of the A. M. A. in Buda-Pesth. To my surprise I found that there was formerly such an organization, but owing to some unfortunate handling there is today no headquarters. The situation in Buda-Pesth regarding postgraduate work is entirely different from Vienna. According to information given me by two American physicians doing work here, one must look over the field and make personal application to the teacher whose work appeals to him. There is the opportunity in this city to obtain actual operative training on the living subject with the Professor standing by. This I understand one cannot get in Vienna or other post-graduate centers without a long period of waiting and then the opportunities are extremely limited. Even in Buda-Pesth the physicians told me that there was not another vacancy until June 1928. Of course private financial arrangements are made for this work. There is plenty of work to be had in the anatomical lab-

oratory in operative work on the cadaver, also in the various types of anesthesia, gastro-enterology, etc. The doctors told me that they were doing work in Vienna and came down to Buda-Pesth several months previous, looked about, made arrangements and when the time arrived came down. So the situation is not for one who wants work immediately. In the summer Buda-Pesth is extremely hot, there is a marked difference in the temperature between Vienna and Buda-Pesth. I would not advise even going there for a visit in the summer if it is possible to go at another time.

Buda-Pesth is a beautiful city with a population of about one million. It has seventy hospitals with a bed capacity of 15,730; it has its university, clinics, fine museums and public buildings of all kinds. The Hotel St. Gellert, referred to above, has connected with it the finest equipped hot baths for men and women I have ever seen. These hot springs in Buda-Pesth, were known to the Romans and are famous for the treatment of rheumatism and joint affections. There is another magnificent bath called the Szechenyi Bath which looks like a palace. One finds three kinds of thermal springs, the St. Gellert, the second has its source in the Joseph Hill in Buda-Pesth and the third is in the level plain of the Lagymanyos. The last mentioned is the bitter water exported all over the world as Hunyadi Janos, Apenta and other names. There are special baths for nearly every kind of treatment, well equipped and up-to-date. It is rare to find a great city that is so completely equipped by nature and man for the treatment of disease by water which is not only heated by nature but of such varied kinds, sulphur, radioactive, bitter, mineral, etc. Among the objects that appeal to America is the statue of George Washington in the city park. The monument that appealed to me the most was on the corner of Elizabeth Place entitled "The Deliverer of Mothers" dedicated to the doctor who made the epoch making discovery that puerperal fever was caused by infection.

*(Semmelweis)*

1818-1865

He was a Hungarian working in Vienna when he made his contribution; his was a sad story. The monument shown here with a mother and the little babes. It is with a sense of pride that one thinks of another name that goes with this great one, the name of an American doctor, Oliver Wendell Holmes, one in America and another in Europe, men who did so much for the mothers of the world. There is much to be seen in this city of two towns Buda and Pesth astride the Danube. The history of the city and of Hungary itself is of great importance in the story of Europe. Names of men like Szehennyi, Andrassy, St. Gellert, Kucsoth and others, who fought for liberty, come to mind. Today the political situation of this country is a sad one and I hope the powers will take the necessary steps to straighten out the tangled affairs of Austria, Hungary and Czechoslovakia who are sulking with discontent. I cannot enter into detail here but data can be easily obtained. Aside from the beauty of its situation, there are fine hotels and restaurants with Gypsy bands, who play the music of Hungary, the opera, nights on the Danube which is not so blue as the name of the waltz would indicate and a kindly people, everything to make you want to stay.

(Post-graduate Suggestions)

In talking with various men I was struck by the dissatisfaction manifested by some against the socalled personally conducted tours for post-graduate work in Europe. They said that the work was so crowded that it was not possible for a man to digest it all. How can a man work from early morning till late at night and comprehend what it is all about? Another objection was the price paid which in some instances was higher than that paid by the individual student. One should consider very carefully before going up with groups. In fact I think it would be better to go alone.

MUNICH

Munich is the most delightful of all German cities, the real Art Center with its wonderful old galleries crowded with pictures, its marvelous Deutsches museum to which we made four visits with its most complete departments of all human effort. I have visited many museums in my travels but this one is unique. It is a university for the people, you may go down and see a complete coal mine, study the movements of the heavenly bodies built by Zeiss, see every variety of airships, railroads, engines, phonographs, alchemist's laboratory, in fact it needs a large volume to simply catalogue what one can see. There is something different in the Bavarians from the rest of Germany. They like lively things, good music, good beer, the best in Germany, good food, in other words

there is a word they have called "gemmikleheit" which describes their characters but which I can't translate in English except to say it is something like "good natured." Munich is a great medical center, the University of Munic, has many famous names on its list, is one of the places where there are excellent opportunities for post-graduate work. Just a few of the names Sauerbruck in surgery, Mueller and Romburg in medicine, Borst in pathology, Hoderlein in obstetrics and gynecology, Lange in orthopedics, Bumke in psychiatry, Neurmayer in ear and eye, gives one a very good idea of the type of work done in this beautiful city. Munich on the Isar certainly has an appeal of its own not only along the line of medicine but to all human desires. There are many delightful excursions to be made from Munich to Oberammergou (scene of the Passion Play) and to various places in the Bavarian Alps mostly b ymotor cars.

PARIS

Paris, where all good Americans go. We were agreeably surprised that the hotel prices were not as high as we had anticipated, from the reports in the newspapers. There is an increase over two years ago and one finds a tax on all meals. One of the delights of Paris of course is eating. Probably in no city of the world can one find such a variety of places catering to the appetite. There are several books published on this important question. "The Gourmet's Guide," "Where to Eat in Paris" and etc. The latest and best all-round book on Paris is one entitled "How to Enjoy Paris" price $1.00, to be obtained at any of the book stores. It is not a guide book like Raedekers or others but a real human guide which I think you will enjoy. It tells you all the places to eat and drink, out of the way historical places, and there is a portion devoted to what you can see within 50 miles of Paris.

I am not going to say anything about sightseeing. Just a few words about medical Paris. The University of Paris has its medical department with an eminent faculty. To the medical visitor in Paris I suggest first taking your passport and going to the "Administration generale de l'assistance publique a Paris" at 3—Ave. Victoria, where you will be given upon request a little pamphlet entitling you to visit the hospitals of the city of Paris. There is a complete list of all the hospitals, clinics, and special hospitals, if you are interested in some specialty, with all the addresses. By the way one should not forget to visit the wonderful collections of models of skin diseases in the museum attached to the Hospital St. Louis, one of the finest in the world. Go to old Salpetriere and see the original drawings made by Charcot. They are stuck away in some bookshelves in his old library. Visit the quaint museum of Dupy tucked in behind the Medical school in an old monastery. And notice how the hospitals of Paris are named after famous men, Lariboisiere, Tenon, Laennec, Bichat, Roussais, Ambroise Pare, Broca, Claude Bernard Tranies, Baudelocque and others. What a roll call of names we revere in medicine.

The other place to go for information is "The Association pour Le Development des Relations Medicales Entre La France et Les Pays Allies and Amis (Information Bureau for Foreign Physicians). Address Salle Beclard Faculte De Medicine, 12 Rue De L'Ecole De Medicine, Paris. Hours 9-11, 2-5 p. m.

Here you will find an English speaking secretary who will give you information regarding post-graduate work in Paris. A map of the city with the hospitals marked on it with the directions for going to them, a list of courses, teachers and various bulletins are also furnished the prospective student. Here is a list of the courses given in English this year:

Recent developments in diseases of chest and lungs—Laennec hospital, Prof. Sergent and Dr. Rist.

Recent developments in Gastro-enterology—Dr. Bensaude, St. Antoine hospital.

Diseases of Heart and Vessels—Dr. Clerc.

Surgery of digestive tract and liver with demonstration on dogs—Prof. Gorset.

Surgery of the nervous system—Dr. De Martel.

Recent developments in surgery—Gregoire, Hertz, Pouchet, Roux-Berger.

Operative courses on cadaver—Prof. Cuneo.

Treatment of chronic disease of bones and articulation—Dr. Colue.

Obstetrics and Gynecology—Prof. Brindeau, Couvelaire, J. L. Faure.

Ophthalmology and oto-rhino-laryngology—Dr. Morax, Lariboisiere hospital.

Ophthalmology and oto-rhino-laryngology—Dr. Lemaitre, St. Louis, hospital.

Diseases of children—Dr. Armand Delille and Weill-Hoth.

Price 50 francs a lesson per person, at present exchange about $2.00 These are

main courses, others may be arranged with various teachers.

"THE AMERICAN HOSPITAL"

One must never forget in speaking about hospitals to say a word about that "Haven of Refuge" for sick Americans in Europe, the American hospital in Paris. The new Memorial building which was completed by public subscription at the cost of nearly $1,000,000 is now able to take care of 120 people. This is the only permanent American hospital in Europe and is recognized as a model of scientific equipment. It is served by English speaking doctors and nurses. The entrance to the hospital grounds is at 63 Boulevard Victor Hugo, Neully sur Seine, about one mile from the Porte Champerret. Don't fail to put it on your list for a visit. I must say a word about one place that was of great interest, the home and workshop of the author of the Humane Comedie, Honore Balzac. The author of "The Country Doctor" which every physician should read, lived in a little house with its garden now tucked down behind a tenement house. This great genius was always in debt and here you can see the trap door down which he fled when creditors came, the little dolls he used to have in front of him as he wrote, the desk, chair and other simple furnishings are still there.

CHATEAU COUNTRY

A short visit was made to Tours and Blois to see some of the Chateau on the Lo with their great historical interest. We visited Chenonceaux, Cheverny, Chaumont, Chambord, Blois and Amboise. The last is of especial interest to doctors because it was here that the father of modern surgery Ambroise Pare was summoned to treat Francis II but Catherine de Medici delayed the proceedings until it was too late and thus had her own way over the two Guises. It is curious how often medicine is mixed in with history, Moliere who lambasted the doctors in his "La Malade Imaginese" and other plays, taken by a fatal stroke while preparing to take the lead in the above mentioned play, what an irony of fate!

One of the newest French books is by Dr. Maurice de Fleury of the Academy of Medicine, entitled "Le Medicine" (The Doctor) very interesting and one of the successful plays on the Paris stage is entitled "Knock" by Jules Romain, in which the medical profession is held up to ridicule ala Moliere.

And now to write "Finis" to vacation days until the call comes again so vividly set forth in that poem loved by my friend, Dr. J. H. Dempster, called "Sea Fever" composed by John Masefield.

*"I must go down to the seas again,*
*To the lovely sea and the sky,*
*And all I ask is a tall ship and a star to steer her by;*
*And the wheels kick and the winds sway and the white sail's shaking,*
*And a grey mist on the sea's face, and a grey dawn breaking.*

*I must go down to the seas again, for the call of the running tide*
*Is a wild call and a clear call that may not be denied;*
*And all I ask is a windy day with the white clouds flying,*
*And flying spray, and the brown spume and the sea gull crying.*

*I must go down to the seas again, to the vagrant gypsy life,*
*To the gull's way and the whale's way where the wind's like a whetted knife;*
*And all I ask is a merry yarn from a laughing fellow rover,*
*And a quiet sleep and a sweet dream when the long trick's over.*

—John Masefield.

## THE SURGICAL ATTACK ON HEAD PAIN

C. F. McCLINTIC, M. D.
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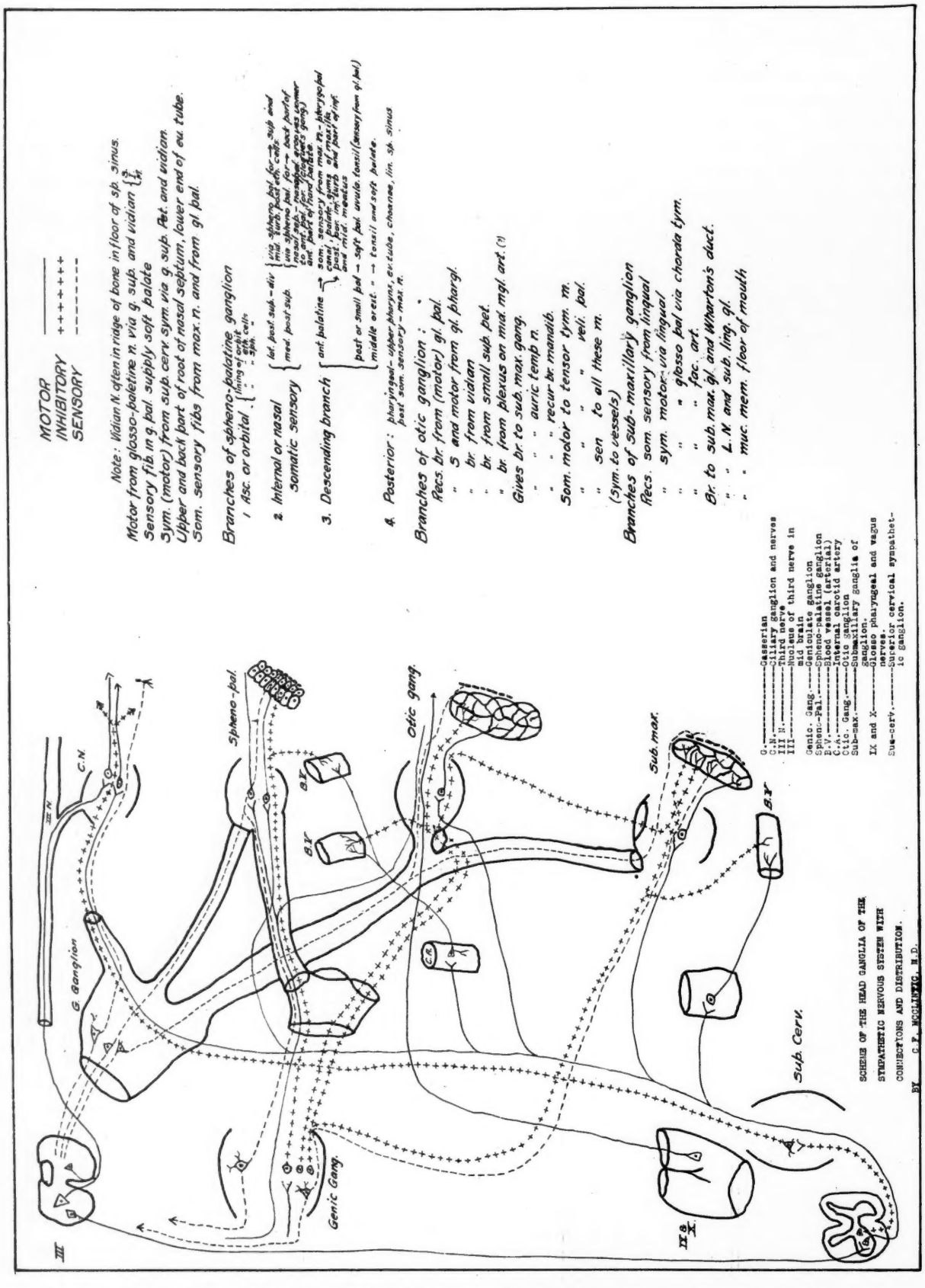
DETROIT, MICHIGAN

For ages the relief of pain in the head regions has been one of the most baffling problems of the medical man. In most recent times, surgery has come to the aid of the internist in this most important problem. It came first with the injection of various substances into the nerves such as distilled water, phenol, glycerin, cocain, novocain and alcohol. These substances when injected into the nerve trunks and ganglia usually give relief for a longer or shorter period of time but none of them are permanent in their effect.

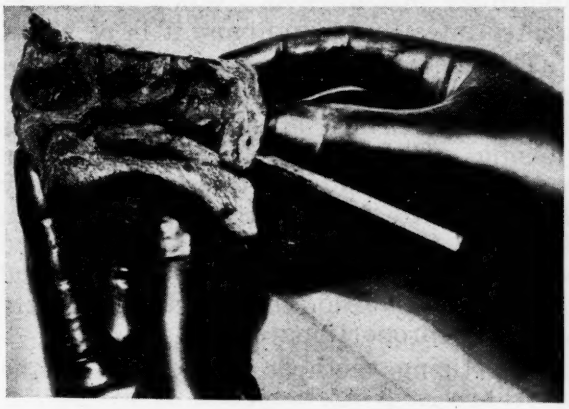
In order to secure either a permanent or palliative result (which is also permanent) surgical interference with the nerves or ganglia concerned must be resorted to. In order to form a basis for the surgical treatment of head pain a knowledge of the distribution of the nerves of the head is essential. Accordingly we have worked out the scheme of sympathetic and sensory innervation of the head as it appears in the accompanying diagram.

The important facts to be observed in relation to pain and the nerve distribution are:


MOTOR
INHIBITORY
SENSORY
Note: Vidian N. often in ridge of bone in floor of sp. sinus.
Motor from glosso-palatine n. via g. sub. and vidian
Sensory fib. in g. pal. supply soft palate
Sym. (motor) from sup. cerv. sym via g. sub. Pet. and vidian.
Upper and back part of root of nasal septum, lower end of eu. tube.
Som. sensory fibs from max. n. and from gl. pal.
Branches of spheno-palatine ganglion
1. Asc. or orbital
2. Internal or nasal
Somatic sensory
3. Descending branch
4. Posterior:
Branches of otic ganglion:
Recs. br. from (motor) gl. pal.
" 5 and motor from gl. pharyg.
" br. from vidian
" br. from small sub. pet.
" br. from plexus on mid. mgl. art.
Gives br. to sub. max. gang.
" " " auric temb n.
" " " recur br. mandib.
Som. motor to tensor tym. m.
" " " veli. pal.
" sen to all these m.
(sym. to vessels)
Branches of sub-maxillary ganglion
Recs. som. sensory from lingual
" sym. motor via lingual
" " " glosso pal via chorda tym.
" " " fac. art.
Br. to sub. max. gl. and Wharton's duct.
" " L.N. and sub. ling. gl.
" " muc. mem. floor of mouth
G.——Gasserian
C.G.——Ciliary ganglion and nerves
III N.——Third nerve
III——Nucleus of third nerve in mid brain
Genic. Gang.——Geniculate ganglion
Spheno-Pal.——Spheno-palatine ganglion
B.V.——Blood vessel (arterial)
C.Ar.——Internal carotid artery
Otic Gang.——Otic ganglion
Sub-max.——Sub-maxillary ganglia of ganglion.
IX and X——Glosso pharyngeal and vagus nerves.
Sup-cerv.——Superior cervical sympathetic ganglion.
SCHEME OF THE HEAD GANGLIA OF THE SYMPATHETIC NERVOUS SYSTEM WITH CONNECTIONS AND DISTRIBUTION.
BY C. F. McCLINTIC, M.D.
C.N
III N
G Ganglion
Spheno-pal.
Otic gang.
Sub. max.
Sup. Cerv.
Genic Gang.
III
IX & X

1. The wide and extensive distribution of the pain or sensory fibers from the spheno-palatine ganglion. (a) This explains the frequency of "referred pains" (erroneously called "reflex pains") from pathological lesions in any of the regions reached by nerve fibers from this ganglion. (b) This also indicates why treatment of these lesions often results in a permanent cure, e. g. correction of a deviation of the

septum will sometimes relieve a chronic headache or other head pain. (c) it also gives a rational basis for injecting the ganglion for head pain when the cause cannot be determined or, if known, cannot be removed.



Median section of nose, showing probe through left anterior nares passing over the inferior turbinate and entering beneath the fold of the middle turbinate at the junction of the posterior and middle thirds. This is the route used in injecting the spheno-palatine ganglion through the nose.

2. The other important point is, that sensory fibers to all the head ganglia pass via the posterior root of the trigeminal nerve. This gives us a basis for relief of pain arising anywhere within the region supplied by branches from these ganglia, by cutting the posterior root of the fifth cranial or trigeminal nerve.

A study of the diagram will also throw light upon many rather vague conditions which arise in parts quite remote from the regions involved, and will enable one to explain many of the trophic, vaso-motor, and visceral disturbances arising either in the head region, or in other visceral areas, as a result of the wide distribution and connections of the chain ganglia of the head, neck and upper thorax, e. g. asthmatic attacks are sometimes permanently removed by treatment applied to nose or to throat.

The chart is so constructed and the legends are so given as to make it self-explanatory. The accompanying photographic illustration illustrates the approach used in the injection of the sphenopalatine ganglion.

## THE DIETARY TREATMENT OF PERNICIOUS ANEMIA*

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Recent developments in the treatment of pernicious anemia have entirely changed the outlook for patients with this disease. The current general attitude of pessimism regarding the condition was presented by Evans[1] in a comprehensive monograph on pernicious anemia published in 1926. Even at that time, however, there were indications of a more favorable future for patients with this disease.

In 1923 Gibson and Howard[2] suggested the use of a diet containing liver, because of its apparent beneficial effect in cases they had been studying from another aspect. In 1925 Whipple and Robbscheit-Robbins[3] demonstrated the value of liver in treating experimental secondary anemias. In 1926 Minot and Murphy[4] reported a series of 45 cases of pernicious anemia treated by a special diet containing liver. They had produced remissions consistently by this diet and the remissions had persisted so long as the diet was continued.

We started treating pernicious anemia patients at the University hospital with a similar diet at that time somewhat less than a year ago. A series of 35 cases have completed their hospital treatment since then with results similar to those described by Minot and Murphy.

### THE DIETARY REGIME

In their original article Minot and Murphy described a diet with the following principal features. We have used the same diet with only minor variations.

1. A daily allowance of 200-250 grams of liver. Calves liver is preferable, but beef and pigs liver may be substituted. Extra meat is given once a day preferably red meats or glandular organs such as kidneys and pancreas. In case of necessity, the latter may be substituted for liver for short intervals, but it is not certain that they contain the specific element present in liver, so they cannot replace it entirely. We are not using as much extra meat at the present time.

2. The fat content is restricted to approximately 70 grams daily for theoretical reasons. If such restriction is disagreeable to the patient a more liberal allowance may be given without any apparent ill effects.

3. The free use of fruits and vegetables is encouraged. A total intake of 2500-3000 calories is usually sufficient.

### CLINICAL CHANGES ON THE DIET

Patients develop remissions with astonishing regularity on this regime. Co-op-

* Read at 107th Annual Meeting Michigan State Medical Society, Mackinac Island, June, 1927.

eration is usually excellent for the diet is not restrictive and while many do not care particularly for liver, they are willing to eat it, because they know it will help them.

Within a few days after starting the diet, patients note a definite sense of improvement usually associated with an increase in appetite and followed soon by a progressive gain in strength. The general attitude and appearance reflect the improvement. Within a few weeks a normal range of basal activity may be carried on without difficulty.

During the first week the blood shows signs of increased bone marrow activity with the appearance of increased reticulocytes and other young red blood cells. This early activity is followed by a progressive and often rapid increase in red blood cells and hemoglobin. This increase varies with the individual, but in the average case the red blood cells and hemoglobin increase more then 100 per cent within the first 3-4 weeks and counts within normal limits are the rule after 2-3 months management.

Follow up observations thus far have shown that the remission persists if the diet is continued. One of our cases developed a relapse after discontinuing the diet for about one month, but promptly improved under further management. Patients must continue the diet if they expect to keep well and close supervision should be maintained after discharge.

### PRACTICAL CONSIDERATIONS

The knowledge of what this diet will do makes the treatment of these patients a pleasure. To be able to promise relief if co-operation is given and predict more or less accurately the course of events produces an unusually favorable state of mind in the patient and those who have suffered under previous systems of management are particularly grateful.

It has been our impression that better results are obtained if the patient is placed in bed during the early stages of treatment. Due to local conditions most of our patients were hospitalized during treatment usually for a period of 3-4 weeks. A subsequent convalescent period of 1-2 months has been advised with another examination at the end of this interval to determine individual fitness for further activities.

It is important to correct irritating factors such as poor teeth, ill fitting false teeth, lack of false teeth, local sepsis or any other process which interferes with the normal ingestion of the diet. Special preparation of the liver as well as the remainder of the food is frequently necessary in these cases.

Hydrochloric acid was given in most cases, but several did not receive it and improved just as well. When it relieves gastro-intestinal symptoms, it is of value.

The marked response to the diet suggests that liver supplies some specific substance which is absent in pernicious anemia. This is important, because in very weak patients or those with a very poor appetite, the liver should be eaten first and then as much of the other food as is desired. This is usually successful and as the condition improves the appetite increases proportionately.

Appetizing methods of preparing the liver are a great help and a variety of recipes offers the best means of overcoming the monotony of the diet.

In a few cases, the condition on entry was so poor that even the liver could not be given. Preliminary transfusions in these cases supplied sufficient strength to start the diet and subsequently all developed remissions. Two patients entered in a moribund condition, dying despite transfusions and before liver could be given.

The various phases of the disease respond differently to treatment. The improvement in the blood is much greater than that noted in the nervous system. In fact improvement noted in the latter can usually be accounted for by the improved circulation and state of nutrition. However, a final opinion can not be given regarding this at the present time. Whether the cord changes will progress or develop if not already present, while on the diet, is an interesting question. It is interesting to note in this connection that the achylia persists during the remission as it does during those which develop spontaneously.

The original work of Whipple indicated that such a diet would benefit secondary anemias. We have treated several cases with variable success. When the primary cause can be found and treated the response is satisfactory. One encounters very frequently anemias of atypical character and it is often difficult to decide whether the condition is pernicious anemia or not. If such cases do not respond after a satisfactory period of dietary management, it is reasonably certain the condition is not pernicious anemia.

In secondary anemias, some form of iron

should be given with the diet. Blaud's pills are satisfactory, although recent work indicates that ferric salts such as ferric citrate are better. Hydrochloric acid may be given if achlorhydria is present. Treatment of the underlying condition is of course fundamental.

The amount of liver required to maintain a remission is unknown. We have continued the same diet until the blood is within normal limits and thereafter advise 100-150 grams a day. Some of our patients have found it difficult to secure fresh liver daily. Cooking several days supply ahead has been satisfactory.

This difficulty plus the monotony of eating liver every day has led to several attempts to obtain satisfactory extracts. Dessicated liver preparations are available, but the dosage is unknown. One of our cases developed a remission on 12 grams of dessicated liver daily. Recently Cohn and Minot have reported the isolation of the essential principle in a protein free fraction of liver. This preparation is now being tested in a group of selected clinics before being released for general clinical use. It will of course be a great advance and will eliminate practically all the shortcomings of the present management.

In conclusion, it may be conservatively stated that the present dietary treatment of pernicious anemia constitutes one of the outstanding advancements in medicine. The use of liver produces remissions by a mechanism as yet unknown. To maintain the remission, the use of liver must be continued indefinitely. If discontinued for very long, a relapse is practically certain.

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## EXERCISE IN THE TREATMENT OF PULMONARY TUBERCULOSIS

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All students of pulmonary tuberculosis are agreed on the importance of rest in the treatment of the disease, but have diversified ideas as to the length of rest. There is little accord upon the importance of exercise. The large percentage of patients discharged from sanatoria as quiescent or apparently arrested, who subsequently break down, presents a serious problem. This failure is often due to the lack of a period of hardening by carefully supervised graduated exercise which is a means of acquiring resistance. The best method of controlling the toxemia and the systemic disturbances is rest. The best method of inducing healing in a tuberculous lesion of the lung is rest. Sufficient rest is very important at the beginning of treatment. Valuable and essential as it is, rest can be over done. We must remember that the majority of patients in municipal sanatoria come from the working classes. It is our problem to restore their working capacity, for without that life to them is useless and a misery.

The average stay in the sanatorium is 12 months. This is a minimum for all cases in the incipient and moderately advanced stages of the disease. Far advanced cases remain a much longer period. Complete confinement to bed necessitating the use of the bed pan should be insisted upon as long as there is evidence of toxemia. Evidence of toxemia consists in elevated temperature, tachycardia, true night sweating, and continued loss of weight. In particularly obstinate cases of fever, immobilization treatment should be tried. The patient is kept recumbent with only one pillow. He is not allowed to sit up or do anything whatever for himself; he is fed by his nurse; he is not allowed to read, or to be read to; and, of course, has no visitors except his doctor and his nurse. This is drastic, but, in many cases, surprisingly effective. If successful it will usually be so fairly quickly, and it is obviously a method which the patient will not submit to very long. If this method does not bring about a complete, or, at any rate, a marked control of the toxemia, the patient has a poor prognosis even in regard to improvement, and requires hospitalization.

Not the extent of the lesion but its quality is the decisive criterion as to the indication for rest and exercise. In patients with a favorable prognosis the maximum amount of healing usually occurs within six months of bed rest. If the lesion is predominantly exudative a longer period of rest is necessary, because we must wait until it has become resorbed or changed into the productive form. Most of the purely exudative processes we see are in young adults, usually under 25 years of

age. Their sputum is positive upon admission to the sanatorium, and remains so. These cases are almost always moderately advanced or far advanced with only a slight tendency towards fibrosis. The prognosis is always poor. It is not so important whether an open or closed tuberculosis exists, as to whether this open case becomes closed. Likewise, the extent of the lesion is not of so great importance in prognosis as the tendency towards fibrosis. A large percentage of the patients in sanatoria are cases of chronic fibrosis which with properly graduated exercises will in time be able to return to their work. Those in the third stage of the disease, who have been ill for two or more years and whose disease is stationary and does not give rise to symptoms or signs of auto-inoculation, do better on exercise than those in the first stage of the disease. A certain percentage of patients in the third stage shed tubercle bacilli at all times, but are free from constitutional symptoms. They are kept in sanatoria in order to prevent the infection of others, but they can well be up four or five hours and take care of themselves, and often they are able to work about the sanatorium and thereby contribute to their maintenance. The pathological anatomical changes in the lungs are not of so great importance in these patients as the determination of their working capacity, especially if they are to be returned to an economical basis. This can only be determined by exercise tests. Cavities are no contraindication to such tests.

The therapeutic value of graduated exercise lies in the fact that it increases the patient's general strength, giving him better muscle tone and also strengthening his heart muscle. In slowly graduated exercise an auto-tuberculinization occurs. One theory to account for this states that the circulation is increased and the areas about the tuberculous foci become more vascular. Small amounts of tuberculin are then poured into the blood stream, thereby stimulating fibrosis and increasing the patient's resistance. Experimental studies as well as clinical experience indicate that the work of the right heart is increased only in extensive pulmonary disease. Patients who die of pulmonary tuberculosis usually show some hypertrophy of the right verticle.

Where the cardiac muscle, aside from the toxemia, is taxed by such complications as chronic bronchitis, bronchiectasis, emphysema, and pneumokoniosis, exercise is contraindicated. Patients with intestinal tuberculosis and those subject to hemorrhage and pleurisy should take no exercise.

At Tegtmeir's clinic most of the patients are men from the working classes in whom the disease is moderately or far advanced. When all signs of toxemia have disappeared and they are able to walk for an hour, they are started on exercise out of doors. He points out that giving the drills out of doors not only tones and brings into play certain skeletal muscles, but that it improves the breathing and increases the vital capacity of the lungs and strengthens the heart muscle and other organs. The air hardens the skin, giving better vasomotor tone. His patients are divided into three groups, all starting in Group I. The drills are held daily out of doors unless the temperature goes below 19 degrees C. in the shade, and are usually started after the rest hour. Only a loin cloth is worn by the patient. The exercise in Group I comprises marching and movements of the arms forward, upward and sidewise to definite counts. The patients are moved up and down in the groups according to the manner in which they react. Many patients remain for an indefinite period in the first group. Each case receives individual observation and management. Rectal temperatures are taken one-half hour after the drill and a careful record of the temperature and pulse is kept. Physical examination and X-ray studies are made at frequent intervals. In this way one soon learns just what a patient can and cannot do. When there are no constitutional symptoms, no change of physical signs, the patient is slowly worked into Group II. The exercises here are the same as in I, with the addition of the movement of the legs, with special attention to breathing exercises. In patients where pleuritic changes have occurred forceful inspiration is contraindicated. Rest periods are often called during the drills and the duration of the exercise depends upon the individual's reaction. No patient receives more than a half hour exercise at a time. The same observations are made as in Groups I and II before the patient is put into Group III. In the last group the drill is as in Groups I and II with the addition of thoracic movements where all the skeletal muscles are brought into play. When an individual can go through Group III exercises for six weeks with no shortness of breath, no signs of fatigue, the physical signs showing no change and

serial roentgen ray studies revealing no new pathology, the patient may with a fair degree of safety be discharged as fit for work. To recapitulate, all cases must be carefully selected. The work must be under the supervision of a physician. It is not the training of groups, but individuals. Favorable results have been obtained from this form of prescribed exercise.

In prescribing exercise we have to consider those patients who were in good physical condition and afebrile from the beginning of treatment; and secondly, those patients who were treated by absolute bed rest on account of fever. At the beginning of treatment all afebrile cases who have well defined active physical signs of pulmonary tuberculosis and who at the same time are in good physical condition, but who do not need strict bed rest, are treated with rest in bed during the morning and afternoon rest periods. They are permitted bath room privileges and may sit up between the hours of 11 a. m. and 1 p. m. and between 4 p. m. and 6 p. m. This routine is carried out for from one to three months. These patients are not allowed any other form of exercise. They should have no signs of active disease in the lungs when they begin graduated walking. Patients in poor general condition and with fever at the beginning of treatment should be treated by absolute bed rest until the temperature and pulse become normal and remain so for a period corresponding to the febrile period. During the afebrile period in bed massage should be given in order to restore muscle tone. In favorable cases the too frequent pulse becomes gradually less frequent and harder, always a sign that the blood vessels are stronger and the circulation is better. The patient may be permitted to rest in the reclining chair. Should any of these bed patients have relapses of fever or other complications, walking exercise should be postponed. The length of time this postponement should last will depend on the severity of the relapse. If it lasts for three or four weeks it is a good rule to keep the patient in bed for two or three months more. This, however, must be left to the judgment of the physician. With but few exceptions the rate of the pulse is as good an index of the patient in regard to exercise as any. So long as it is 90 or more per minute, or it is accelerated to that rate by mild exercise, the prognosis is not good. The question may well be asked, what standards are to be used in the correct grading of exercise? This is a difficult question to answer with exactitude. Personal experience is necessary, but the method of procedure can be analyzed down to fairly definite rules. Exercise may be slowly increased as long as all signs of systemic disturbance are absent; that is, as long as a carefully kept temperature and pulse shows no definite abnormality, as long as the body weight change is satisfactory and as long as a careful questioning of the patient elicits no feeling of malaise.

Careful study of the temperature and pulse charts should be supplemented by more minute testing of these phenomena after definite amounts of exercise. It is very important to examine the patient immediately after his afternoon exercise, making notes of his general appearance, looking for fatigue, undue perspiration, paleness and cyanosis. The pulse, respiration and temperature are then taken, and after a five minute rest interval the pulse rate is taken again, and again after half an hour interval. In this way one can classify the patients under three headings. (1) Those with a normal pulse, respiration and temperature; or moderate rise of pulse and temperature, which returns to normal within five minutes. (2) Those with an unduly rapid pulse or raised temperature, which do not return to normal in five minutes, but do so in half an hour. (3) Those with rapid pulse or raised temperature, which do not return to normal in half an hour. Patients on exercise should never show a temperature maintained for half an hour. The question may arise, just what is normal temperature? An occasional rise to 99° in males and 99.6° in females is considered to be within normal range, according to the rule followed at the Trudeau Sanatorium. The pulse rate must be considered in relation to each case, as tachycardia is not necessarily evidence of intoxication; that is, when the heart is working under abnormal conditions because it is displaced by artificial pneumothorax or by fibrosis, definitely placing an obstacle on the pulmonary circulation, decreasing the alveolar ventilation. The patient's first form of exercise is usually a walk to the bath room. The first few times the pulse may go up to 120 and sometimes to 130. A pulse of 120 at the beginning of exercise is not necessarily a bad prognostic sign. It is more important to determine how long it takes the pulse to return to a normal range. If each day the pulse remains more and more within normal range the bath room priv-

ileges may be increased. When the patient's chart shows a normal temperature and a pulse rate of not over 100 he should have all bath room privileges and be started to meals. Often the physician is puzzled as to which meal to send the patient. If the patient has a rise in temperature it is most likely to occur in the afternoon. Therefore, it is not advisable to send him to the dining room in the evening. Breakfast and the noon-day meal are preferable. If the patient goes to the noon-day meal he will usually rest longer in the morning. Going to meals is not always considered as exercise by patients. When asked how much exercise they are taking, they often reply. "A ten minute walk." Upon further questioning one often learns that they are also going to all meals. Taking meals in the dining room is exercise, because it means that the patient must get up and dress each time. When patients are going to all meals they should be started on walks. These walks should be increased according to the patient's physical records. Walking is the usual form of exercise prescribed for sanatorium patients. Graduated labor as distinct from graduated walking, was first used as a routine sanatorium procedure in England by Marcus Paterson. In grading the work, he prescribed practically any kind of work that could be done under sanatorium conditions. In Grade I the patients carry small baskets, weighing about seven pounds, varying distances up to three miles. In Grade II light hoeing, hand weeding, and light painting were prescribed. No rapid work is allowed, and no work involving the sudden or continued application of great physical effort such as lifting, axe work, or straining with a heavy load in a hand cart. All work must be done without any distress, dyspnea or palpitation. The results obtained from this graded labor were, on the whole, as good as the results obtained at other sanatoria.

It is most important that no patients be considered for discharge until they are able to work six hours each day and are free of all constitutional symptoms. There are very few places that have sheltered employment for the tuberculous. In most instances when a patient leaves the sanatorium he must compete with healthy men in a factory on an eight-hour day basis. If he is not trained for the task he will soon have a relapse.

Most sanatoria have a supervisor of reconstruction. Occupational therapy may be divided into three parts, which are practically three stages in its remedial application. (1) Divisional therapy, in which simple amusements, such as games and puzzles, are used to occupy the fingers and divert the mind. (2) Occupational or handicraft therapy, in which definite tasks are assigned, involving the doing of useful things with woods, beads, textiles, clay, metals, etc., for the purpose not only of occupying the mind, but of assisting in the restoration of lost or weakened function. (3) Prevocational training, in which the prescribed remedial agents are employed for the distinct and studied purpose of leading up to definite education and training for some industry or trade. Only a few sanatoria are able to give their patients free vocational training. There is no greater fallacy than the advice to tuberculous people to get light out of door employment. There is almost no such thing as a light out of door job. If it is found it will also be discovered to return a light pay envelope. But good wages are necessary for the healthful maintenance of a tuberculous man and his dependents. The records of the Gaylord Farm Sanatorium showed that the factory workers held their condition distinctly better, and the office workers far better than did the out door worker.

The National Tuberculosis Association's Advisory Committee to the Federal Board for Vocational Education came to the conclusion that it was necessary to offer certain standards or factors to be considered in counseling with the tuberculous. Those adopted are divided into four main groups, each with five subheads: The factors in Group I relate to the personality of the patient, (1) his present health, particularly as to the amount of damage done by the disease processes, and the degree of arrest shown by the medical records; (2) temperament and education, for it is necessary to know whether he is "high strung or phlegmatic, stupid or quick of perception, and the extent of his education and training"; (3) his hopes and ambitions must be taken into account; (4) age will have a direct bearing on vocational education; (5) the sex of the patient must be considered, both for training and placement.

Group II comprises the factors due to conditions of work. (1) Is it active or sedentary in character; indoors or outdoors; heavy or light; involved or simple? (2) Attitude and position are important, for any work requiring a continuous stooping or strained position would be unsuitable. (3) Time, duration, and pauses: is

it to be day or night work? It must not be seasonal, requiring intensive application at certain times of the year. Speeding up is dangerous. Tuberculous people should not work more than eight hours daily; some must work less. (4) Fatigue, tension, and responsibility; lifting of heavy weights and vigorous exertion of the upper extremities must be avoided. Continued nerve strain and too much responsibility are dangerous. (5) Are wages on the per diem or piece work basis, and are they adequate for the patient's needs?

Group III comprises factors due to materials and processes; the kind and quantity of (1) dusts; (2) poisons; (3) gases and fumes; (4) infectious material; (5) dangerous machinery and appliances.

Group IV comprises the factors involved in the place of work. (1) Tuberculous cases should not work in high winds nor under a burning sun, nor in slush or rain, nor in super-heated shops. (2) The construction of the work place: flooring is an important item. Basements, underground areas, and overcrowded shops should be avoided. (3) Air: ventilation, temperature, and humidity; (4) light and illumination; (5) sanitary comforts must all be considered.

### CONCLUSIONS

The value of rest has been well established, but little mention has been made of the importance of graduated exercise in the treatment of pulmonary tuberculosis. Graduated exercise has a definite therapeutic value in restoring the patient to the community as a fit working unit. These patients must be carefully selected and under the supervision of a physician at all times.

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## ABORTIONS

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The treatment of abortions can and should be standardized. It has been noticed that in private institutions where many men handle cases, these cases are treated in as many different ways often with serious results. It is also noticed that in public institutions where the patients are under control of a common plan of treatment, according to the teaching of one particular principle, the results are uniformly better.

The first consideration of abortion to the patient as well as to the doctor, is hemorrhage. This should be considered from two points of view: the immediate seriousness and the remote seriousness.

When the hemorrhage is most alarming the surgeon will frequently treat such a case radically, when such hemorrhage can and should be controlled by more conservative means.

In reviewing the statistics one will be struck with the absence of death from hemorrhage during the early months of pregnancy. A statement from F. Adair in a large clinic of patients, never saw a single death from hemorrhage. Hegar never saw a fatal case of hemorrhage in the early months of pregnancy. In an analysis of some four thousand cases in a Frankforter Clinic not a single case died from hemorrhage. It may be concluded that death from acute anaemia is rare or impossible in the first three months of pregnancy.

The remote dangers from hemorrhage is serious and every means should be resorted to control this hemorrhage. If the patient has become anaemic because of this hemorrhage she is more liable to infection. Because of this remote danger it should give the surgeon no excuse to enter the uterus with his hand or any other instrumentation. The attendant should prepare himself and cause the patient to be prepared with most rigid technic. The vagina to be examined for membranes and if a portion or all of the retained secundae are within the os, this may be carefully removed without entering the uterus. The vagina and cervix may then be firmly packed, the packing to be removed in twenty-four hours, when the products of conception will be discharged or easily removed from the cervix. Ergot is not advised in these cases, it seems to immediately aggravate the hemmorrhage; codeine does not arrest the hemorrhage and should not be used in place of morphine (Adair).

Two series of cases were taken, one according to the teachings of a common plan and another group of cases that were treated by many different men. The first group, 217 cases, the second group, 115 cases. Of the first group not one was treated with immediate dilatation and curettage; of the second group 66 had moderate or severe hemorrhage, 33 had immediate dilatation and curettage. In the first group of 217 cases brought to us from the poorest hygiene and poorest surroundings, none of which were treated with immediate dilatation and curettage, not one death resulted. Of the second group 115 cases, with no organized routine, there were five deaths.

I have classified abortions under the following headings: "Threatened Abortions, "Induced Abortion," "Inervitate Abortion," "Infected and Non-Infected," "Incomplete Abortion with Infection or Non-Infection," and "Complete Abortion," each heading to be discussed alone.

### THREATENED ABORTION

In threatened abortion a great deal of blood could be lost and the patient still go on to term. Cases treated in an expectant manner may often turn out to be only threatened abortion when inevitable was expected, so many cases are treated operatively when expectant treatment should be tried. Any case of pregnancy associated with backache, moderate hemorrhage, etc., should be treated as threatened abortion and kept in absolute rest in bed. Avoidance of cathartics during pregnancy should be strictly observed for many abortions may be precipitated by this means.

If hemorrhage has failed to stop after rest in bed, morphine and by other conservative means, and definitely established as inevitable and there is no temperature, no leucocytosis and no other evidence of infection, with strictest surgical technic the uterus may be emptied. Plenty of time should intervene to determine positively that the abortion is inevitable and that there is no evidence of infection. In this series of cases, thirty cases of threatened abortion which carried to term.

### INEVITABLE ABORTION

It is often difficult to state when a threatened abortion becomes inevitable. The discharge of odorous fluid, escape of amniotic fluid, bits of membrane will definitely decide it to be inevitable. If there is no evidence of infection, the absence of temperature and leucocytosis, with proper technic there is no danger in emptying the uterus. In this series, fifteen cases classified as inevitable, nine of these cases were non-infected.

### INEVITABLE ABORTION WITH INFECTION

If there is serious hemorrhage it should be controlled by vaginal packing, to be removed within twenty-four hours, when the uterine contents may come away or be easily removed. In infected inevitable cases without hemorrhage the patient should be left alone until afrebile for several days. In any case in which the uterus had been entered it should not be subsequently reentered. If a slow bleeding continues, wait until the temperature and leucocytosis are normal and all tenderness considered, then intervention if necessary.

It is relatively safer to use instruments in the uterus under ten weeks than later because the uterine wall is much firmer. It may be necessary in cases beyond eight weeks to use vaginal packing, bougie or bag before uterine contents can be removed which should be done carefully with forceps or finger. The use of the curet should be avoided in these cases.

### INCOMPLETE ABORTION

McPherson figures that about 13.7 per cent of cases are complete, leaving about 86 per cent incomplete. The incomplete abortions according to Williams, have a ratio 5:1 in hospital cases and about 3:1 in general practice. Paul Titus estimates 66 per cent are incomplete. Some authors go so far as to state there is no such thing as complete abortion. Veneberg in an analysis of 287 cases of incomplete abortion at Mt. Sinai hospital found 60 with a temperature from 101 to 105. All of these cases were curetted as promptly as possible after admission. There were two deaths, making a mortality of 3 per cent. In our series there were sixty-five cases with temperature of 101 to 106. None of these were curetted immediately. There were no deaths. In our series eighteen were curetted only after temperature and acute symptoms were subsided.

Hallis studied a series of cases at the Cook County hospital, analyzing 200 cases which had a minimum temperature of 100 on the day of admission. They were divided into two groups of one hundred cases each. In group 1 the uterus was emptied artificially and promptly; in group 2, treatment was expectant. He found that the cases treated expectantly had fewer days of fever; shorter days in the hospital and a lower mortality. He concluded that no patient should be operated unless the patient is afrebile for at least five days. The uterus could then be emptied for continued hemorrhage. Results are as follows: Cases treated expectantly have a lower mortality. The number of days in the hospital are shorter and the convalescence is also shorter. Nonseptic cases should be curetted as a routine, because (1) 40 per cent have to be curetted, (2) curettage insures an empty uterus and prevents subsequent bleeding, (3) it shortens the stay in the hospital, procedure is relatively harmless and accomplishes good. The average number of days of temperature running from 100 to 106 was seven days. After the patient becomes afrebile it is possible to discharge them from six to twelve days. If an afrebile patient who has been hemor-

rhaging, is curetted she may be discharged in five days. We have in our series, 60 cases of induced abortions, of these 33 were septic.

It is advised by some (Boldt) for incomplete abortion, hot antiseptic douches. This procedure and the possibility of disseminating infection is increased. So far as hemorrhage, in relation to incomplete abortion is concerned, we have already indicated that the immediate danger from hemorrhage is practically none, there being no fatal case of hemorrhage in all series of cases. The remote danger from hemorrhage is slight unless infected. The important point of attack in these cases is not so much to control the hemorrhage as to prevent infection. The cases of abortions which usually are infectious are self induced, criminal abortions or those cases of spontaneous abortion which are subjected to vaginal manipulation, without vaginal manipulation the percentage of infections from abortion would be almost none. When vaginal examinations are indicated, it should be conducted with the most careful aseptic precautions.

We can safely conclude that retained products of conception except so far as they provoke hemorrhage, are in themselves not dangerous to the patient. Incomplete abortions are not dangerous unless infected. Briefly, the treatment of incomplete abortion infected, consists of expectant treatment interference only to control bleeding, rest in bed, plenty of fluid, good food, and an abundance of fresh air.

#### COMPLETE ABORTION

This case rarely presents much difficulty from the standpoint of hemorrhage. Non-infected cases require no treatment except rest and general hygiene measures. Infected cases should never be treated actively except for drainage of the uterus, when malposition exists and drainage of the localized abscesses. In a total of 210 abortions, 55 abortions were complete, 8 of these cases were infected and 47 were non-infected.

We have had six cases of therapeutic abortions during the year. Many cases of threatened abortion will not reach inevitable abortion if proper care and instruction is given to the expectant mothers. Many mothers have one abortion and many will have another unless properly cared for. McPherson found that 27 per cent of the cases having abortions gave history of previous abortions. Thirty-nine in one series had previous abortions or 14 per cent. We had 210 abortions and 1068 births in this hospital, a ratio of 1:5.

The treatment of repeated abortion requires careful study to determine the cause. Too frequent repetition of pregnancy, especially repetition following abortion. At least six months or a year should take place before subsequent pregnancy should take place. Mechanical conditions of the uterus such as malposition cervical lacuation are a factor in many cases. Twenty-three of our cases had uterine pathology.

Infection and infectious diseases may be causative factors. Twenty-four had various forms of infectious diseases such as G. C., lues and acute infections.

Syphilis has been overestimated for an early cause of abortion. This disease is more disastrous in the latter half of pregnancy. Only five cases in our series had demonstrable syphilis.

Prophylactic treatment in the most cases is the removal of the cause when the cause can be found. The avoidance of strain or undue fatigue, improvement of the general condition of the patient, administration of corpus luteum in selected cases, rest in bed, uterine sedatives, avoidance of undue emotion and excitement of any kind.

## SOME REMARKS ON MEDICAL TEACHING IN SWEDEN, ESPECIALLY CONCERNING OBSTETRICS AND GYNECOLOGY

ELIS ESSEN-MOLLER, M. D.
Professor of Obstetrics and Gynecology at the University of Lund, Sweden

When you are facing an old Swedish Professor of Obstetrics and Gynecology, I suppose you are not especially interested in hearing a lecture on some topic which you can hear just as well, or better, from your own teachers or read in your excellent American text-books.

I prefer to give you something that you don't find in your books, namely, a short account of how our medical studies are arranged in Sweden, especially concerning obstetrics and gynecology, in order that you can compare with American conditions and draw your own conclusions. I only ask you to be lenient with me, both because I can't speak your language fluently

* This paper was read before the students of Detroit College of Medicine and Surgery at the invitation of Dean MacCracken, during the Clinical Congress of the American College of Surgeons, October 1927. As it seems of unusual interest, though never intended for publication, I have the writer's permission to do so.—B. H. Larsson, M. D.

and because I did not know until two days ago that I had to give this address, which therefore necessarily must be a short one.

Sweden has only three universities with medical schools, Lund, Stockholm and Upsala, but in spite of that Sweden has, of all civilized countries I know of, the longest medical studies, as they cover a period of eight to nine years. Thus a student, who begins his medical studies at 18 years of age, cannot expect to pass examination before the age of 26 or 27 years. If he wishes to specialize in any line, he has to get the special training, and thus reaches 30 years or more before he is ready to practice. If this is an advantage or disadvantage, I shall not enter upon here. I can only tell you how it is and will try to explain it.

The studies are divided into two parts, giving two separate degrees. The first one which we call the Candidate of Medicine, contains only the theoretical subjects, anatomy, physiology, chemistry and so on, and requires about four years. Only after that examination is a student admitted to the second part, which we call the Licentiate of Medicine, and which contains the clinical subjects, internal medicine, surgery, pediatrics, etc. and which requires four to four and a half years. Until he has passed this second examination, he is not allowed to practice.

Now, what characterizes the second part of the studies and what causes it to take so long a time, is the obligatory clinical training in the hospitals. To make this clear let me tell you that this clinical training takes ten months for surgery eleven months for internal medicine, three months for pediatrics and so on. As the students are not allowed to combine more than a few of these subjects, you will understand why our studies take so long a time. As compensation the students get a very thorough and good training in the different lines before they are beginning general practice.

If I now go over to my special line, obstetrics and gynecology, I must first tell you two things. First, that obstetrics and gynecology are united in Sweden, not divided, as here in America and England. In Sweden they form one subject. The professor is teaching both of them, as we think it artificial to separate them and not good for the teaching. Secondly, that the professor of obstetrics and gynecology, when appointed to that chair, becomes at the same moment chief obstetrician and gynecologist to the corresponding University hospital. We have practically no private hospitals in Sweden—all of them are run by the government or the state. The professor has a very good and solid position—he has all his patients in the hospital, even the private ones; he can devote all his work to one place, where he does the teaching, the operations and all things necessary. He cannot be dismissed, but he must retire at the age of 65 years. He is, as you call it here a full time professor, who is not required to split his work or his energy between separate places; no private hospitals, no nursing homes, only the University hospital—that is all.

You will be interested to know that the clinical material, the number of cases, is very good and sufficient for the teaching. That is due to a very remarkable change of public opinion, which is going on since rather a long time. The women now understand that the parturition can be attended with complications and are therefore well aware of the fact that delivery in a well equipped hospital means an added security as compared with the delivery in their homes. What is remarkable is that this does not only hold good with the poorer class of people, but to the same large extent with the well-to-do women from the upper classes of society, who in increasing number seek the aid and quiet of the hospital.

A very important contributing fact is that the costs for the patient in our hospitals are very low. In the general wards, our patients pay up to three or four Swedish crowns—that is about $1 a day, and besides that, the professor has the right to relieve up to 20% of the patients from paying if they are unable to do so. The private patients pay an amount of about $3 per day. During my stay in the United States, I have seen hospitals where private patients pay $25 to $30 per day.

Now, this proves that our clinical material is good. My department at the University hospital in Lund has 108 beds and has every year 2,700 patients, of which 1,800 are obstetrical cases. It may be of interest to you to add that during the last 10 years the number of children born in the Swedish Lying-in hospitals has increased from 15 to 30 per cent. It is also quite certain that this increase will go on in the same manner and it is rather to be expected in the future that more children will be born in the hospitals than in the homes.

Now as to the training of the students in obstetrics and gynecology—they must

do four months work in the hospital. Every four months, eight students are admitted at a time. During those four months they live in the hospital as internes and what seems very important, they are not allowed to occupy themselves with any other subject or any other clinic.

During the first two weeks, they get an introductory teaching in normal pregnancy and labour and then a training in performing obstetrical operations on manikins. After that, they are admitted to attend normal labours in the delivery-room, at first under the supervision of myself or my first assistants, but later independently and on their own responsibility. In Sweden we think that it is most important that the students get their training in practical obstetrics in the hospital before they are going out into practice. It is safer for the patient and it is safer for themselves.

In the same manner, they are allowed to make an application of forceps or a version, of course under supervision, just as they are obliged to call on the resident doctors in any abnormal case. Furthermore, they have to join in the professor's daily visit in the wards, to make the records and the ordinary examinations, and to be present, by day or by night, at operations for obstetrical interferences.

This arrangement has prevailed in Sweden since about 1850 and now I suppose you are interested in the results. Well, I can't tell you about the result of teaching, because I am myself a part of it. But I can give you some figures to explain what it means. Every student at the end of the four months has himself conducted an average number of 45 normal labours; has made one or two applications of forceps, a version or other obstetrical operation and about 60 gynecological examinations. We think that gives a certain guarantee, that he is able to make a gynecological diagnosis, and to conduct safely the labour to the satisfaction of the mother and of himself.

I remarked in the beginning that our medical training is very long; many people think it too long, and that it ought to be shortened. It may be so—I don't deny it, but it is interesting to note that notwithstanding many suggestions in that direction, nobody as yet has suggested any alteration of the time-honoured arrangement of the obstetrical and gynecological teaching, which has now stood the test for more than half a century.

I should perhaps also try to give you a glimpse of the characteristic features of Swedish obstetrics and gynecology, such as I understand them. The Swede is cautious and reserved. New schemes are taken into consideration and carried out only after thinking it well over and after getting the conviction that they can't do the patient any harm. Also the respect for and confidence in the work of nature, itself, is deeply rooted in the Swedish obstetrician, and the unnecessary interference is looked upon as what it really is, a superfluity. A suggestion such as doing a version at ordinary parturition, only in oder to shorten its course, is simply unthinkable in Sweden.

Another example is the symphyseotomy, which at the end of the last century witnessed its revival. It has never gained ground in Sweden. The admirable construction of the pelvic girdle is too respected to risk making a fissure in it, and we are suspicious of the risk of producing deliberately a complicated fracture. That is the reason why there have only been a few operations of this kind performed in Sweden, and why they have not been followed by others. Not even during the climax of the popularity of symphyseotomy or the hebosteotomy could it gain a footing in Sweden, although not to perform it was almost regarded as a sign of being left behind. I think that the experience has shown that we are justified in our reserve.

This reserved position with regard to the operation does not depend upon a fear of surgical interference by itself, for the surgeons at the hospitals in our country have a thorough surgical training, and their results can stand comparisons with those of other countries.

Similar phenomena are met with in the gynecological line. We have not but in rare exceptions, wanted to try the new narcotics in the form of intravenous or rectal narcosis which have seen the light in recent years. It seems to me as if the critical reserve even in this line has been safer than a premature experimenting which has in some cases already proved to be followed by serious drawbacks.

In this connection I cannot help mentioning a case of which the opinions may differ, that is of the surgical treatment of the retroflexed uterus, such operations are not but exceptionally made in Sweden, for we do not believe in the clinical significance of the retroflexion, and as a consequence its operative treatment is out of the question.

I could continue to enumerate several examples of this critical reserve which, according to my opinion, characterizes the Swedish obstetrics and gynecology. Its weakness is to be found in the fact that with such an attitude against new ideas, the Swedes are not among the first to publish their experiences with new methods, but in that respect keep in the background. Its strength, however, is just as obvious; it consists in the greater security of the patients, who are now subjected to experiments with new methods until these, after a careful examination, have proved to be both harmless and advantageous. Such a standpoint seems to me reasonable, even from a scientific point of view, in the sense, that it does not very easily give rise to reverses but gives a certain confidence in an even and continued evolution.

Before finishing I wish to add a few words to you, upon whose shoulders many of the tasks of the future are to be laid. What has interested me very much during my stay in your country is the very great difficulties you have to grapple with in medical teaching and standardization, but also the energy and the enthusiasm with which you attack them. There is no doubt, I think, but that you will conquor them thoroughly and splendidly. But don't forget, my young friends and colleagues, that organization of teaching and of hospitals is not all. The main point is the spirit which penetrates them. The medical profession demands conscience, feeling of responsibility, devotion, unselfishness and charity. If those qualities are predominating in the doctor, then, and not until then, is he what he ought to be. Then he has something more than a profession—a calling for which it is worth to live and to die, for there is nothing more noble, more high or more heavenly on earth than the privilege to relieve something of the suffering of mankind.

## PLEXIFORM NEUROFIBROMA OF THE MEDIAN NERVE—

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### CASE REPORT

*History*—Patient, white, 22 years old, sheet metal worker, first noticed a swelling in the palm when seven years old. This caused no trouble until it began a rapid enlargement a few months previous to our observation (June 21, 1926). With the increase in size, pain and numbness were observed. "Pins and needles" sensation after holding any object tightly, aching at night and in the morning, and a progressive loss of power of the hand were also noted. Numbness in the hand brought on by holding something tightly would disappear if the hand was held down and shaken.

*Examination*—Left palm revealed two swellings, one about 4 c.m. in diameter, between the first and third metacarpals and overlying the second metacarpal, and the second smaller mass between the thenar and hypothenar eminences at the bases of the metacarpals. No signs of inflammation. The skin moved freely. Masses were firmly fixed in place. The larger mass had a very definite palpable outline and was smooth and tense. The smaller mass was more irregular, more closely applied to the skin and had a "doughy" feel. Flexor tendons were free. No changes in the circulation of the fingers could be observed. No muscle atrophy, although the grip on this side was distinctly weaker. Pressure over the larger mass caused a pain and a paresthesia in the hand, but no local pain and no radiating or referred pain along the course of any nerves. General physical examination was negative. There were no other enlargements in the subcutaneous tissues nor along the nerve trunks.

*X-Ray*—Stereoscopic anterior-posterior plates showed normal bones and joints and a well defined soft part shadow in front of the second metacarpal (Plate No. 3).

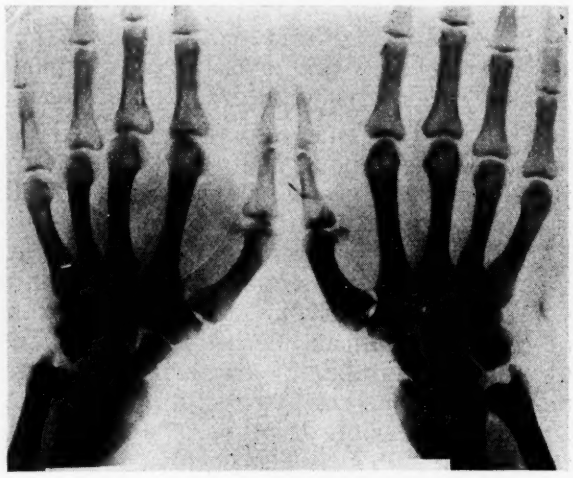

Figure 3.

X-ray A. P. View, Showing Shadow of the Mass over the Second Metacarpal.

### TREATMENT

Operative removal was undertaken through a curved incision in the palm (June 24, 1927) (Plate No. 1). The smaller mass had herniated through the palmar fascia and was removed by section of its pedicle. The larger mass presented a very difficult dissection from the underlying structures. It was superficial to the flexor tendons and to the superficial arch. Two extensions of the tumor attached it closely and firmly to the thumb and first finger. At this time it was thought inadvisable to remove the tumor beyond the anterior transverse carpal ligament. Wound was closed with catgut. The wrist was put up in moderate hyperextension with the fingers flexed over a roller bandage.

Pain over the sectioned end of the median nerve

Figure 1.

Artist's Drawing of the Operative Field showing Location of Incision and Tumor Masses.

and anesthesia over the dorsal surface of the first and second fingers and the palmar surface of the thumb and adjacent first, second and one-half of the third fingers, and anesthesia from the base of the fingers to the incision were noted immediately post-operative. The pain became less marked and the splint was removed after six days. The fingers had fair motion and power, but they were lacking in co-ordination. No atrophic changes observed. Two weeks post-operative there was a distinct paresthesia in the first, second and third fingers. A distinct "shock-like" pain referred to the first and second fingers was present in movements of the wrist, or stretching of the palm, and especially on pressure over the carpus. Pain only very slight at the end of three weeks. A mass 1.5 c.m. in diameter had developed in the volar aspect of the wrist about 5 c.m. above the upper limit of the incision.

Dr. J. E. Lehman removed this upper mass (Plate No. 4) and the remaining portion of the involved median nerve, which was enlarged to the "size of the index finger for about 4 c.m. up the arm." Operation about November 29, 1926. At the level of this resection only a portion of the circumference was involved. Healing was normal and complete freedom from pain resulted. There is full movement of the hand, though maladroit. Co-ordination is impossible.

Laboratory report of operative specimens:

Specimen consists of a tumor 6 c.m. x 3 c.m. x 2.5 c.m., completely encapsulated except at the sectioned ends (Plate No. 2). One cut surface is composed of 30 round, shining, fibrous structures varying in size from 1 m.m. to 3 m.m. The other cut surface is composed of 5 similar structures leaving the growth at varying angles. Microscopic examination shows a mass of loose vascular connective tissue in which lie about 30 or more greatly enlarged and thickened nerve trunks. The increase in size is due chiefly to an overgrowth of the connective tissue elements of the epineurium. There are many dilated blood vessels. The microscopic picture of the specimen removed by Dr. Lehman shows the same overgrowth of connective tissue (Plate No. 5).

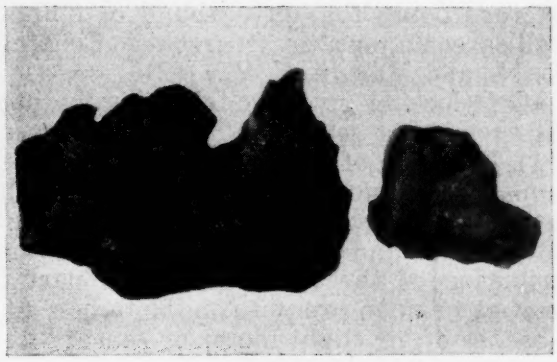

Figure 2.

Retouched Photograph of the Specimen.

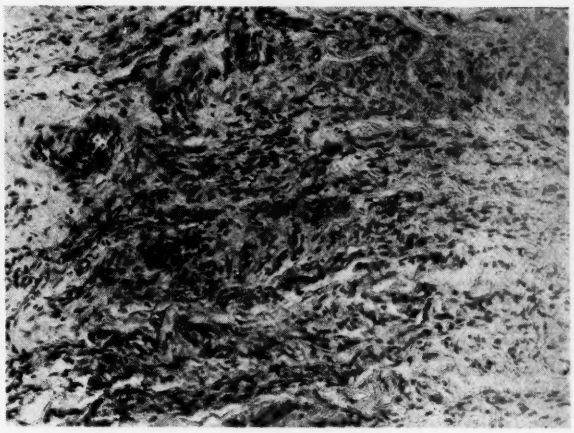

Figure 5.

Microphotograph of Specimen Removed by Dr. Lehman. X 150.

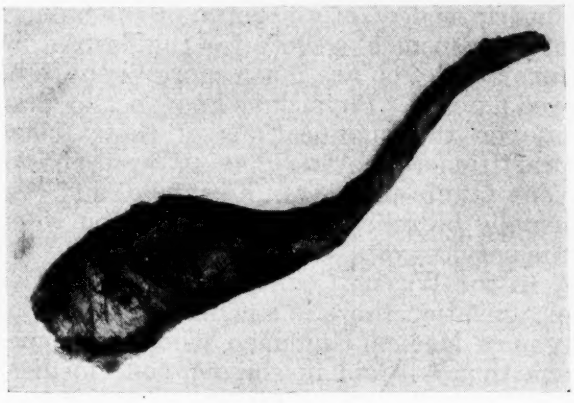

Figure 4.

Photograph of Specimen Removed by Dr. Lehman.

## DISCUSSION

Neurofibromata not associated with the general disease are uncommon, as are also tumors of the palm. Ott (1) reports nine

such cases at the Mayo Clinic. These tumors may arise from any of the connective tissue structures of the nerve trunks as pure fibromas, or they may arise from the more specialized nerve tissues as a pure neuroma. Generally it is found that the more rapid growing tumors of this type arise from the epineurium. In the present case the overgrowth was from the epineurium, with no atrophy of the specialized nerve substance. Neurofibromata are considered to be congenital in origin, due to some malformation of the ectoderm. This is especially true in the generalized neurofibromatosis. Solitary neurofibromata have a marked tendency to undergo sarcomatous degeneration, the microscopic picture being that of a round or spindle cell sarcoma, or a myxosarcoma (Fleming, L. N., and Marvin, E. W.) (2).

Ott (loc cit) gives the following findings as those of a solitary tumor of a nerve: (1) Presence of a tumor in the region of a nerve, (2) mobility of the tumor at right angles to the course of a nerve, (3) pain at the site and along the peripheral distribution of the nerve when the part is moved, or upon pressure on the tumor, (4) absence of, or slight motor or sensory disturbance, (5) history of long duration and slow progress. In the case reported no symptom was present which could not be easily accounted for by the presence of the growing mass upon the underlying structures. The pre-operative diagnosis was uncertain and not until sectioned at operation was the true nature of the tumor apparent. The choice of operation lies between enucleation of the tumor, leaving the nerve fibers intact, and excision of the nerve. Amputation of the extremity might be indicated if it was an extreme case of sarcomatous degeneration. In the plexiform type of tumor, and especially those near or involving the terminal branches of a nerve, enucleation is impossible. Enucleation of fibromas with preservation of the nerve fibers, when such tumors occur in the course of a nerve, is the operation of choice.

### CONCLUSION

(1). Report of uncommon tumor of the palm.

(2). The choice of operation depends upon the complexity and the location of the tumor, as well as the histological structure.

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## HEALTH TALKS

G. VAN AMBER BROWN, M.D., F.A.C.S.
DETROIT, MICHIGAN

The Wayne County Medical Society with a membership of over 1,400, is the fourth largest County Society in the world. It is composed only of physicians, graduates of approved medical colleges and licensed to practice medicine in the State of Michigan. As a society we are interested in the relief of human suffering by the prevention and cure of disease whether mental or physical.

One of the recent of many methods, being developed in the Wayne County Medical Society to combat disease, is a plan for instruction of the laity regarding measures they should be familiar with that are preventive of disease, in whole or in part.

This Society has adopted as a part of its campaign the idea of giving broadcast talks from this station, W G H P, Retroit. This is the first of a series to be given each Monday evening at 6:15 to 6:30.

During this introductory talk you will be told of some of the subjects that are to be dealt with during the weekly programs that are to follow, and of some of the other things that we, the Wayne County Medical Society are trying to do in behalf of the people of this great commonwealth, the State of Michigan.

It might not be amiss just here to advise those of you who have recently located in the village or city where you now live, also, those who contemplate taking up residence in some new locality, the proper way of selecting a physician. First, let us advise you not to go to some strange family next door for guidance. Their pet physician may not be at all the type desired. You know, society people often think a doctor is a great physician while physicians know him only to be a great society man. When in need of medical care, if you will call on the superintendent of a hospital or the officers of your medical society for the desired information, you are much more likely to be well advised. Physicians know better than laymen the qualifications of their fellow practitioners. After having first chosen your family physician, he should, and can, usually be relied upon to direct you when the services of a specialist are needed.

In the Wayne County Medical Society's organization there is a committee, the Bureau of Medical Guidance, who have someone that will aid in solving your medical

* First of a series of radio talks broadcast over W. G. H. P. under auspices of Wayne County Medical Society, November 21, 1927.

problems if you will telephone into the headquarters any day of the week from 12 to 1 o'clock; or better still, write or call at the Society quarters located on the 11th floor of the Maccabee Building, Detroit. Here many inquiries come pouring in every day and it is always a pleasure for this committee to unselfishly lend aid without charge for the service rendered, working always in a close and harmonious way with the physicians, boards of health, poor commissions and hospitals of Wayne County. Being a branch of the State Society, also of the American Medical Association, our Society functions according to the standards and ideals of these parent organizations. This leads me to state what characterizes the true physician as set forth in the May, 1927 issue of that splendid lay magazine, Hygeia.

The education of the true physician is attested by the degree of Doctor of Medicine from some worthy institution of learning. His moral, ethical and professional standing is attested by his membership in his county, state and national medical associations. His standing as a man (or woman) and as a citizen is attested by precisely the same standards applicable to others. His legal standing should be attested by his license to treat the sick. He considers the patient rather than the disease, and he utilizes all proven knowledge and any or all proved methods in the treatment of his patients. He recognizes that every patient and every human being, for that matter, needs advice calculated to avoid and prevent health dangers, to correct existing troubles and to prevent their repetition or progress. He knows that the infirmities of the body, mind and soul are inseparably linked together so as to require all that science, art and personality can bring to bear in the patient's behalf. He renders what he can of these services and he delegates the others wisely. He understands that no person can know or practice to the best advantage all phases of the great field of medicine and health; and therefore, whenever indicated and feasible, he asks other physicians for the assistance he needs. He either maintains or has contacts that insure adequate consultation, laboratory, X-ray, nursing, hospital and all other services necessary for the welfare of his patients. He follows the moral code of his profession, which insures confidential, sympathetic, consecrated service to his patients in such volume and at such times and in such places as are provided. He neither indulges in nor permits personal puffery. When his name is seen in the public press, it is usually as the author of some dignified statement about the condition of some patient whose welfare is a matter of public concern. More rarely he may give an authorized interview or write an article for public information on some health subject. He relies for the growth of his own clientele on the influence of the ever-widening circle of those friends whom he has served.

He will admit that the best medical education is often inadequate and he will endorse the statement of Hippocrates that experience is fallacious and judgment difficult. But he feels that physicians are the only persons even remotely prepared by education and training for leadership in matters pertaining to improvement of health, the limitation of disease and the treatment of the sick. He thoroughly examines and carefully studies his patients, and he always makes written records of his findings. He is never boastful or inclined to discuss his patients with others. He never guesses; when in doubt, he says so, and invites consultation or assistance. He realizes his responsibilities and approaches his problems with the humility, seriousness and earnestness of purpose that ever characterizes the servant of God, of man and of science.

How does your doctor measure by this standard?

Beside the things we have been talking about, you may be interested to learn further of some of the activities of this great organization, The Wayne County Medical Society. For instance, it has within its ranks various committees, the duties, a very few of which we will here briefly review:

1. Public Education Committee who adopts measures for dissemination of information affecting the health and the general welfare of the public and under whose direction these lectures are being given.

2. The Committee on Health and Public Instruction whose duty is to carefully investigate and consider all matters of publicity of legislation having a sanitary, hygienic or other medical relation.

3. Legislative Committee whose duty it is to keep in touch with any impending legislation affecting the hospitals and the health of the public.

4. The Committee on Medical and Civic Relations whose duty is to investigate all matters of medico-civic interest and make such recommendations to the governing bodies as it deems advisable.

5. There is the Nurses Committee who makes careful inquiry into the condition of the nursing profession of the county and adopts such measures as may be deemed advisable to enhance services of nurses.

6. The Cardiac Committee to assist in any program for the prevention of heart disease, to foster the interest of cardiac research among the members of the Society and to keep the Society informed of any progress made in any phase in the treatment or diagnosis of heart disease.

7. The Cancer Committee is actively interested in the ultimate solution of the cancer problem.

8. The Maternal Welfare Committee whose duty it is to investigate matters of material welfare in Wayne County and to make such recommendations to the governing body of the Society as will assist in furthering the cause of better obstetrics.

These constitute only a few of the many problems with which this Medical Society is working. For instance, there is the scientific program with an evening meeting each week devoted to the study of disease, at which hundreds of physicians gather regularly to hear papers read and discussed by men known nationally and internationally. At noon two days a week there is a gathering of the younger physicians of the profession of Wayne County, who meet in our medical quarters and discuss ably indeed the problems of the art and science of the practice of medicine. It would do the heart of any man or woman good, whether physician or not, to hear these sincere young doctors, sixty or more of them at each one of these meetings, discussing with deep earnestness, the problems of medicine, seeking to improve themselves and others in their chosen life work, that they may relieve human woe.

In concluding, may I invite and urge you to tune in every Monday evening at 6:15 on W G H P, Detroit, and hear one of our members talk regarding these health measures, each having a direct bearing upon the welfare of every human being in this and every country, not only of present but of future generations. For the subject of health and disease is as broad as humanity itself.

## NOTES ON THE NEURO-SURGICAL CLINICS OF GREAT BRITIAN, FRANCE AND HOLLAND

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Having spent considerable time in the study and observation of neuro-surgical work in New York, Philadelphia and the Mayo Clinic, the writer decided to see if the clinics east of the Atlantic had any thing to offer the neuro-surgeon of the United States.

Due to the limited time and realizing that one should remain some time at each service in order to properly evaluate the work, the writer visited only the clinics in London, Edinburgh, Paris, Strasbourg and Amsterdam.

The first thing that impresses the American physician, especially on the continent is that a surgical specialist usually works in quite a wide field of surgery but from the field he selects some particular phase of the work, very much as we Americans take up a "hobby," and in this particular phase he invests his time and effort.

Mentioning just one or two phases of surgery in general; except for the American hospital in Paris and the Children's hospital in Edinburgh, the hospitals both as to buildings and equipment in no way compare with our modern hospitals as seen in every large American city. The equipment is also old and to us appear quite antiquated. Their plumbing is atrocious, and would never pass one of our building inspections. While a few surgeons have designed some rather ingenious instruments, yet there are very few if any that haven't their counterpart in the United States. Their technique in asepsis and antisepsis almost brings a chill to one trained in our methods.

To note a few of the particularly interesting phases of their work which is rather novel:

In London, at the National hospital an operation for the relief of intractable pain has been tried out which consists of splitting the spinal cord in the mid-sagittal plane. By this means all of the pain fibers from both sides of the body are severed, thus serving the purpose of a double ventral chordotomy as practiced by us.

In Edinburgh a very beautiful result has been obtained by perforating the septum between the lateral ventricles of the brain in unilateral hydrocephalus. However the differential diagnosis of the condition, and the basis for the operative technique was acquired in American clinics.

In Strasbourg, the place where periarteriorraphy and sympathatectomies were first successfully practiced there exists a lot of enthusiasm for the proceedures. The work is being done in the University of Strasbourg. In addition to an abundance of clinical material a very generous allow-

ance is made for laboratory workers so some very interesting scientific work is being done. The latest development consists in treating varicose and indolent ulcers by first doing a femoral periorteriorraphy and eight days later removing a ring of skin about the ulcer and then doing a skin graft. The results are very striking, and the treatment is worked out on a good scientific basis.

Probably the best organized neuro-surgical clinic in Europe is that at the University of Amsterdam presided over by the illustrious Professor B. Brouwer. He not only has a mass of clinical material at his disposal but also a wonderfully efficient and large corps of well trained assistants. He is especially interested in neuro-pathological work and in neuro-histology but this is beautifully correlated with his opperative neuro-surgical clinics and his animal experimentation laboratories. One can see the cases on the wards and then enter a laboratory across a small court and study the tissues of cases in all points similar to those observed in the wards. His most interesting work is on the pathology of internal hydrocephalus. This appealed especially to the writer because it confirms our suggestion of laying open the cerebellum and aqueduct of Sylvius from the Thalamus to the Medulla for this condition.

While the distinguished de Martel does a great deal of neuro-surgical work in Paris yet we found nothing there different from our work in this country.

In Belfast the principal neuro-surgeon is more particularly interested in Urology, a branch in which he is internationally known.

In all the clinics with the exception of London, a very high regard is entertained for the American surgeon. The majority of the more progressive surgeons expressed the thought that they all desire to visit the United States to see our work. Even in London a great many of the leading physicians and surgeons are from the United States and Dominion of Canada or have studied in schools of the Western Hemisphere.

If we American physicians would thoroughly familiarize ourselves with the science of modern medicine as taught in the average medical school in our own country we would discover upon going abroad that about all we learn there can be found at home. The chief advantage of such a trip is that it gives us the assurance that there is not anything worth while anywhere in the world in medical science that has not been appropriated by the wide awake American physician and surgeon. In seeing medicine and surgery as in sight-seeing, "See America First."

## LORD LISTER'S INFLUENCE ON MODERN SURGERY*

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*"And he stood between the dead and the living; and the plague was stayed."*—Numbers: XVI. 48.

"It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to Heaven, we were all going direct the other way—in short, the period was so much like the present period, that some of its noisiest authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only."

The late years of the eighteenth century thus described by Dickens, the years just preceding the American and French Revolutions, were not unlike those following Napoleon and Waterloo. There was little change. In spite of political revolutions in America and France, in spite of an intensified feeling of intellectual and moral liberty and in spite of the beginnings of the great industrial or social democratic movement, the nineteenth century in its early years showed little of promise. It was an age of enlightenment, it was an age of darkness, it was a period of science, it was a period of empiricism and theory. The hair-splitting theoriests of the eighteenth century sitting in their gilded salons were still captivating the populus. The world laughed at Fulton's steamboat, Stephenson's locomotive was a delusion, Soemmering's electric telegraph was a toy, Darwin's expedition on the Beagle mere idling. Jenner's vaccination was an object of popular depreciation and Lavoisier, the chemist, was beheaded by the Commune. Though medicine was rapidly becoming a science and surgery was more than an art, as Semmelweis well said, "All was doubt and difficulty, only the great number of dead was an undoubted reality." In short,

* Awarded First Prize by Detroit Academy of Surgery.
* Read before the Detroit Academy of Surgery, November 10, 1927.

the period was one of struggle and strife between the forces of Empiricism and theory on the one hand and the scattered adherents of Science on the other. The time was ripe for a change, and the ensuing years were to witness the Renaissance of Science.

The year was 1827. Brilliant discoveries in the field of medicine were being made. The first great contribution to American medical science had been made two years previously when Beaumont in Northern Michigan observed in "fistulous old Alexis" the secrets of gastric physiology. Richard Bright in England was solving the riddle of nephritis, the Bells in Scotland were uncovering the mysteries of the nervous system, Addison had not yet made his discoveries. In the field of microscopic anatomy, Schleiden and Schwann were teaching the cellular basis of life, Liebig was revolutionizing chemistry and Laennec had succumbed the year before, himself a victim of the "white plague," whose pathology he has so accurately described.

Surgery at this period, while brilliant, was not progressing with the same rapid stride as was medicine. Since the days of Percival Pott and John Hunter in the previous century very few outstanding surgical discoveries had been made. There were many minor advances, but none comparable to the re-discovery of ligatures by Pare and the ligature of aneurisms by Hunter. After Hunter, surgery had ceased to be regarded as a mere technical mode of treatment and had begun to take its place as a branch of scientific medicine, firmly grounded in physiology and pathology. But advances were slow, discoveries few and improvements, if any, were largely of a technical nature. Outstanding figures like Sir Astley Cooper, the pioneer of vascular surgery, must be recognized, and Ephraim McDowell, who performed the first successful ovariotomy in the frontier town of Danville, Kentucky, in those pre-anesthetic times, must excite our admiration. Speed, skill and daring were the outstanding characteristics of the surgeons of this time.

"When I was a boy," writes Sir Clifford Allbutt, "surgeons operating on the quick were pitted against the other like runners on time. He was the best surgeon, both for the patient and the onlooker, who broke the three minute record in an amputation and a lithotomy." Cheselden performed a lithotomy in 54 seconds and spectators at Fergusson's Clinic were advised "to look out sharp, for if you only wink you'll miss the operation altogether." Langenbeck once amputated a shoulder while a colleague present was taking a pinch of snuff. But in spite of such great dexterity, their field of usefulness was small. Their accomplishments were overshadowed by an overwhelming mortality which put to naught whatever knowledge and skill they possessed. The surgery performed was the surgery of necessity. Operations of mere expedience were looked at askance. Superstition had it that such operations were "tempting Providence" and would be followed by disaster. "The patient laid on an operating table," said Simpson, "was in more danger than the English soldier on the field of Waterloo."

*"Ars longa, vita brevis."* The growth of human knowledge is by a slow and almost imperceptible process. Science progresses through periods of inactivity to periods of action, from times of barrenness to times of fruition. The occasional brilliant advance comes as a startling revelation and the ensuing period though enriched by the new acquisition may be one of veritable stagnation.

> "Ages elapsed ere Homer's lamp appeared,
> And ages ere the Mantuan swan was heard
> To carry Nature lengths unknown before;
> To give a Milton birth asked ages more."

What Cowper says of literature is not untrue in many respects of science and particularly of those applications of science upon which the welfare of humanity depends. Events which today go unnoticed may be regarded as epoch-making in future years when their practical value is justly appreciated. Fulton's steamboat was ridiculed. Though its first trans-Atlantic voyage was considered a great achievement, it remained for later generations to appreciate the boon which has been conferred upon humanity.

At this time there lived in the little English village of Upton a London wine merchant whose humble home was brightened on the 5th of April, in the year 1827, by the birth of a son, Joseph Lister, who was destined to dispel this chaos of sepsis by which even his own birth had been hazarded. Humble and obscure origins frequently mark the birth of men of genius; poverty rather than wealth provides the stimulus for the development of great character; comfortable and auspicious surroundings generally beget a *savoire faire*, rather than diligence and a knowledge of fundamentals. The life of Joseph Lister proves a remarkable exception to

this rule. He was born of Quaker parents whose quiet home life reflected little of their easy circumstances. They were well-grounded in learning and culture and with high, indeed rather austere ideals of morality, were particularly desirous of fostering these same standards in their children.

"In the field of observation," said Pasteur, "chance favors only those who are prepared." In Lister's life heredity, associations and early training were especially auspicious. His father was by avocation a well-known microscopist who, three years after the birth of his illustrious son, perfected the achromatic lens. For this achievement he was elected a Fellow of the Royal Society. Optics and microscopy were his hobby and very early he aroused the interest of his son in these pursuits. This is well shown in Lister's early writings, for soon after his graduation from the University of London in 1852, he published an essay on the use of the microscope in which he advocated what is now known as clinical microscopy. Just as Pasteur's microscope was called "an impracticable instrument fit for scientists only," so the contemporaries of Lister feared that the microscope would "sound the death knell of clinical observation."

"Opposition," said Pasteur, "is a useful stimulant," and so it proved with Lister. Nothing daunted by the deadly conservatism of his opponents, he continued and made a number of original histologic studies in which he verified Kollicker's observation that the iris consists of smooth muscle. The trend of his studies at this time was purely scientific. We hear nothing of surgical learnings and it was only at the behest of his two teachers, Sharpey and Graham, that Lister went to Edinburgh to study under the famous Scotch surgeon, Syme. His intention was merely to spend a few months at this clinic, but the interest aroused by this great teacher and the special aptitude of the pupil soon lengthened the period until in 1854 Lister was appointed house-surgeon at the infirmary. Three years later he was engaged in researches on inflammation, realizing that a proper understanding of this condition could only be obtained by a thorough understanding of morbid anatomy. He said at this time, "At the present day, more especially when theory is allowed such free scope, and is permitted to attack the most time-honored rules of practice, we stand in peculiar need of the beacon-light of correct pathology, to enable us to steer a safe course amid the various conflicting opinions which assail us." It was at this time that he showed experimentally that injury to the vessel wall was the causative factor in blood coagulation. He observed the increase in the blood supply of the tissues subjected to irritants. He saw in the microscope the changing calibre of the arterioles and capillaries and the increased number of circulating erythrocytes but overlooked entirely the associated influx of leucocytes and the process to which Metchnikoff many years later gave the name "phagocytosis" (1884). A few years later he gave his paper on excision of the wrist for caries. For these achievements he was elected, at the early age of 33, a Fellow of the Royal Society. Technically his surgical results were excellent and yet in the series of six cases in which he had performed excision of the wrist, three developed hospital gangrene and one pyemia.

Lister at this time was travelling along the same lines as other members of the profession. In some respects, however, he already stood apart from the great majority as well as the leaders since his work had been largely physiological and because his constant aim was to found his treatment and explain phenomena upon a physiological basis. Every surgeon was discouraged by the prospect that, however perfect he might render his art, his results would always be doubtful and he might well say with Pirogoff, "But we shall soon see how often chance and how much that is still dark and obscure for us in surgical practice comes so prominently forward that all these qualities (such as skill, judgment, etc.) are completely paralyzed thereby." Many efforts were being made to dispel this uncertainty and many had attempted to remove the element of chance which impeded surgical advances. Up to 1865, however, no appreciable light had been thrown upon the subject and it is at this time that Lister's association with contemporary practices comes to an end.

Lister's first introduction to septic diseases came early in his career when, as dresser in the surgical wards at University College Hospital in London, he was dismayed to see his first patient develop phagedenic gangrene. Similar disasters were repeated only too often and in spite of painstaking care and a constant effort to prevent their occourrence no improvement was obtained. While pursuing his studies on inflammation and blood coagulation in 1865, Lister arrived definitely at

the conclusion that putrefaction of the blood and wound discharges were closely related to the development of septic disease, and that the only means of preventing sepsis was to combat putrefaction. Like others of his time, he could not account for the etiology of putrefaction. Some thought it was due to the gases in the air, especially the oxygen, which acted upon the organic fluids of the wound; others presupposed the existence of indefinable substances called miasms which supposedly emanated from unhealthy regions and were carried by the air to the open wound. Such theories were eminently unsatisfactory. John Hunter had shown in the previous century that oxygen itself did not cause sepsis since injuries to the thorax produced by fractured ribs which punctured the pleura and allowed air to enter the chest never developed sepsis. No other explanation was offered and consequently the theory of miasms persisted.

In the light of present day practice it is difficult to realize the horrible conditions which existed at the time when Lister was beginning his surgical career slightly more than sixty years ago. "A pin prick is a door open to Death," said the French surgeon Velpeau. That door widened before the smallest wound, accidental or operative. Surgeons hesitated before the slightest operation; even the lancing of an abscess or a whitlow was often followed by serious consequences. Suppuration was almost invariable and strangely enough occurred more frequently in hospitals than in private practice. It was even much worse in cases demanding surgical intervention. Thus the operation of ovariotomy first performed by Ephraim McDowell was discouraged and often prohibited, and, because of the great mortality due to sepsis, some went so far as to consider the operation "classed among the attributes of the executioner." Thus an eminently useful operation was almost discarded because of circumstances over which the most adroit technician had no control.

Following these suppurating wounds there appeared waves of rapidly spreading sepsis in the form of erpsipelas, "hospital gangrene," pyemia, and septicemia ending frequently in death. Compound fractures were particularly fatal. Operations upon the abdominal and pelvic viscera were too often fatal and the surgical procedures most often carried out were amputation and ligations of blood vessels. The surgical field, though remarkably widened in 1846 by the advent of anesthesia, was still narrowed by the prohibitive mortality which prevented even the boldest from straying from the well-trodden path. The theory of miasms stood in the way of progress for such a relationship between patient and disease could not easily be remedied. Since the beginning of the nineteenth century surgery had not advanced—it had positively retrograded. Mortality after operations in preceding centuries was less because, albeit unknowingly, antisepsis had been practiced through cauterization by fire, boiling oil and disinfecting substances. The Good Samaritan who poured "oil and wine" upon the wounded traveller was practicing the same surgery as was recommended in 1749 in a popular handbook entitled "Medicine and Surgery for the Poor." "It is very salutary, when uncovering the wound in order to dress it, to begin by applying over its whole surface a piece of cloth dipped in hot wine or brandy." The nineteenth century had no improvements to offer,—here and there exceptional men showed signs of divine discontent with the attitude of resignation, but by 1860 no essential progress had been made.

Many famous surgeons of the time were giving the problem of sepsis much thought. Chief among them was Simpson, who first introduced the use of chloroform and acupressure. He collected statistics in a series of more than 2,000 cases of amputation performed in hospitals as well as 2,000 performed in country practice. Their analysis showed that not only was the mortality greater in hospital practice "than in private practice, but that it increased exactly in proportion to the size of the hospital." To the question, "Why is hospitalism so dangerous to the sick?" he gives the following answer:

"There exists, I think, evidence on this question tending to show that the constitution of the surgical patient in the surgical wards is liable to be endangered sometimes by the influence of morbific contagious materials from the bodies of other inmates, though the blood poisoning which leads on to pyaemia is generally produced by inhalation of organic and other materials which usually exist in the air of hospital wards, but which are not contagious."

Mortality statistics in those days, as compared to present day averages were appalling. To quote Erichsen, "In the Edinburgh Infirmary mortality after amputa-

tion was 43 per cent, at Glasgow, 39 per cent, Paris, 58.8 per cent, Pennsylvania Hospital, 24.3 per cent, Massachusetts General Hospital, 26 per cent, military practice, 75 to 90 per cent. The total average mortality in metropolitan hospitals in England was 38.3 per cent, of which 6 per cent was from pyaemia alone."

At this period, Lister's mortality rate after amputation was 45 per cent.

The consensus of opinion being that septic diseases were due to "hospitalism" the prophylaxis employed was reasonable enough. Old buildings were destroyed, new ones took their places, but still the plague persisted. To quote again from Erichsen:

"But surely no stronger or more conclusive evidence is needed of the tenacious and ineradicable nature of this pyaemic infection when once it has taken hold of a hospital—what name so appropriate as "hospitalism" for a condition of things such as is here described. The town is free from infection; the hospital saturated by it, to such an extent as to induce its own surgeons to recommend their patients not to enter it, to compel them to refrain from operating, and, after every attempt that science and humanity can suggest, every hygienic means employed in vain in the fruitless attempt to eradicate the pestilence 'from the very fabric itself' to cause the governors, as a last resource, to decide on the demolition of the building and its complete reconstruction, at a great expense as an only remedy. The truth is that when once a hospital has become incurably pyemia-stricken, it is as impossible to disinfect it by any known hygienic means, as it would be to 'disinfect' a crumbling wall of the ants that have taken possession of it, or an old chees of the maggots which have generated in it."

Such conditions made surgery a sad calling for the beginner. It was almost an even chance whether patients would recover or die; and, if they recovered, if their convalescence would be uneventful, or retarded by suppuration. Elective operations, however, were done for all that, and, when the surgeon had closed the wound, "He was," as Volkman said, "like a husbandman, who having sown his field, waits with resignation for what the harvest may bring, and reaps it, fully conscious of his own impotence against the elemental powers, which may pour down rain, hurricane and hailstone."

Before the new era which Lister inaugurated in 1865, other men had also seen the light, but their voices were unheeded and their victories unsung. In science as well as in other human endeavors, no great man stands alone. Great as he may be he is yet a social product and his achievements reflect the labors of the immortal dead. The genius of Bach is heard in Beethoven and the discovery of Newton reflects the wisdom of Kepler and Galileo. Genius does not arise by spontaneous generation. As early as 1843 Oliver Wendel Holmes had recognized the contagiousness of puerperal fever and had devised efficient prophylaxis. Five years later in Vienna Semmelweis had made the same observation, instituted the same treatment and proved his theory by his results. Holmes was violently opposed, his contribution unrecognized. His was truly the "voice of one crying in the wilderness." Semmelweis was rewarded by a similar though more cruel fate. Brooding over the cruel persecution to which his contemporaries subjected him, he became insane and died a martyr to the cause of antisepsis. A happier fate rewarded the efforts of the last and greatest of Lister's fore-runners. The discovery which made Lister's contribution possible came from the sister-science, biology which had been advancing with rapid strides.

It is necessary to digress at this point to trace the development of a discovery made by a French chemist. This young scientist was Louis Pasteur, the greatest benefactor of mankind in recorded time. He turned from his accustomed paths toward the unknown land, much against the advice and warnings of his distinguished teachers, Dumas and Biot, who feared that the promising youth might lose his way. Pasteur's first independent discovery was made shortly after his graduation from the Ecole Normale in 1847. In this he founded the science of stereo-chemistry by his brilliant researches on molecular dyssymetry in tartaric and racemic acid. It was this discovery which made possible the development of many useful drugs, chief among which is salvarsan, first synthesized by Ehrlich.

It was a great step from the field of chemistry to the studies on fermentation which next claimed his attention. This process has always aroused his curiosity; he had often observed it in his studies in racemic acid and had always remembered the prophetic words of Robert Boyle, the celebrated English physicist, who, two centuries before, had made the prediction that

"whoever could probe to the bottom the nature of ferments and fermentation would probably be more capable than anyone of explaining certain morbid phenomena." In 1857 he showed that the process of fermentation was inseparable from the activities of minute microscopic organisms to which he later gave the term "microbe." The origin of these germs at this time became the object of many violent controversies, Leibig and his adherents claiming spontaneous generation *de novo* of living from non-living materials, Pasteur claiming that this theory was incompatible with the facts he had observed. Fermentation did not and could not take place in even the most favorable media if the microbes present in the circulating air were excluded. He demonstrated in 1863 that "diseases" of wine were due to unfavorable fermentations and that they could be prevented by destroying the causative organisms.

Thus we may observe the evolution of a discovery conceived in the field of chemistry which was later to prove the key to the solution of the surgeon's dilemma. Thus the man who had never handled a scalpel, who shuddered before any surgical operation, who could not even witness suffering in an animal, became the leader of the medical profession and "led them into the kingdom which they longed for but could not obtain for themselves." We see in Pasteur the perfect type and figure of that intellectual passion which makes for scientific progress. It remained for a chance circumstance to prove the practical value of Pasteur's work in surgical practice. The story of how Lister supplemented and applied Pasteur's discoveries is the most fascinating chapter in the history of medicine.

The subject of putrefaction was ever uppermost in Lister's mind and the frequent confidante of his many worries and perplexities on this subject was Thomas Anderson, professor of chemistry at Glasgow University, where, since 1860, Lister had occupied the chair of surgery. While the two were walking home one evening in 1865, Anderson spoke of certain publications by Pasteur relating to the causes of fermentation and the controversial question of spontaneous generation. Lister, who had hitherto been unfamiliar with continental literature, at once procured these papers, and, after reading the famous "Memoire sur la fermentation appelee lactique," became convinced that a solution for his problems was at hand.

But Lister's was an inquiring mind. Before he could proceed he must himself test the truth of Pasteur's statements and verify his experiments. "Genius," says Carlyle, "means the endless capacity for taking pains," and in Lister this capacity was endless. He not only repeated many of Pasteur's experiments, but also devised others of his own to fit the problem with which he labored. In him Pasteur's favorite aphorism "Chance favors the prepared mind" finds its most dramatic application. The years spent in patient, thorough experimentation gave him the necessary preparation to perceive the real value of Pasteur's work, and very soon he was able to formulate his application of Pasteur's principles. Quite by accident he read of the use of carbolic acid and "its remarkable effects upon the sewage of the town of Carlisle; the admixture of a very small proportion not only prevented all odor from the land irrigated with refuse material, but, as it was stated, destroyed the entozoa which usually infest the cattle fed upon such pasture." This fortunate observation removed the last obstacle and from then on his problem was to perfect his technic. Many antiseptics were tried but none gave as good results as carbolic acid.

Lister's struggle was a romantic one. We may think of him with his courtly manner and indomitable courage, as one of Arthur's Knights sallying out single-handed to hunt out and destroy a mighty foe. Inspired only by a theory he vanquished his enemy with a bottle of crude carbolic acid. His enemy was invisible but his ravages could be seen on every hand; his mode of attack, his place of abode, his habits of living were obscure. All Lister knew was that he foe was probably a minute unicellular body belonging to the vegetable kingdom. Few were better prepared than he to carry on the fight, few would have had the necessary courage to struggle against the ridicule and prejudice of his contemporaries. But Lister was convinced of the truth of his principle and its enormous benefit to mankind.

The momentous events which took place at Lister's Clinic at Glasgow during the spring and summer months of 1865 were far from theatrical in the effect which they produced. The studies were carried on under tremendous difficulties for Lister selected only the most unfavorable cases on which to try his treatment. Surgeons even today view with great concern any compound fracture. Infection is the frequent complication and the damage done by in-

vading organisms has often brought about disaster before the surgeon is consulted. Such was the case with the first patient on whom Lister applied his treatment. Death resulted, for the patient was septic, almost moribund, when Lister sought to effect a cure.

Such a result might have caused many less inspired investigators to give up in despair. Lister, however, was confident that given a suitable case, his treatment would bring results. He waited patiently for such cases to arrive. We read graphic accounts of the patients as they were admitted to the infirmary. Factory workers with mangled hands, children crushed by heavy vehicles and trampled by horses, men and women with compound fractures of every type and description soon completed a long series of instances in which the antiseptic principle was tried. Even in favorable cases the results were often far from brilliant. The carbolic acid first used in its crude state often caused as much destruction of tissue as the injury itself. Gradually, however, through a process of trial and error a technic was developed which brought results. Using only dilute solutions of carbolic acid and observing the rigid precautions against bacterial invasion Lister wrought the miracle of modern surgery. Mangled limbs healed by the Hippocratic ideal of first intention and the hectic flush of the septic patient, hitherto a common sight in surgical wards, became a rarity. It was only after he had collected a convincing series of successful cases that Lister determined to publish his results. His mortality rate by the new method was only one-third of his previous record. Morbidity and resulting deformity were reduced to a minimum. We may imagine Lister's joy in contemplating his results, for surely death had been "swallowed up in victory."

The visitors at Lister's Clinic were greeted by a striking innovation. The odor of carbolic acid which permeated the atmosphere presented a sharp contrast to the "good old surgical smell" of former days. Clean gowns replaced soiled frock-coats; care and deliberation supplanted the speed and dexterity of the old regime. Those who hoped to witness operations performed with the show and finesse of the prestidigitator were doomed to disappointment. They saw instead, a scholarly figure engrossed in his struggle against infection proceeding with the careful exactitude of the anatomist. The old glamour had gone; the spectacular surgery of the old masters was replaced by a complicated, dilatory routine. The field of operation, scrupulously cleansed with soap and water was covered by a spray of carbolic acid issuing from the "donkey engine" pumped by an assistant. Carbolic acid everywhere! On the instruments, on the dressings, on the ligatures, on the patient himself. None but carbolized objects touched the wound. The aim was constantly to prevent the access of living bacteria, and to destroy by the antiseptic properties of the acid those organisms floating in the air and harbored in the wound. The technic was anything but a pleasant one. Fingers and hands became white and numbed by the acid, and many less inspired and less conscientious surgeons rebelled against the practice. But the Chief, ever mindful of the horrors of sepsis, ever hopeful of his ability to prevent them continued steadfastly in his painstaking routine.

"Fort mit dem Spray," was the edict of one of Lister's German contemporaries who denied the antiseptic principle. The spray *was* eventually relegated into disuse by Lister himself, but only after he became convinced that air-borne bacteria were negligible and that the real source of infection was the surgeon himself. Time has dispensed to a large extent even with the antiseptic method and has substituted the aseptic mode of treatment. Asepsis as now practiced differs only in principle from Lister's method. The modern surgeon applying Lister's discovery that infection results from bacteria introduced at the time of operation uses only materials which have been rendered bacteria-free. Instruments, dressings, ligatures, even the gowns and gloves which the surgeon wears are sterilized by heat. Listerism hoped to destroy infection, aseptic surgery aims to prevent it. Lister's principles, however, remain. The fact that organisms present in the air, on the instruments, dressings, and the very hands of the surgeon himself, are responsible for suppurating wounds is forever established.

Like Holmes, Semmelweis and Pasteur before him, Lister met with fierce opposition. None understood his principle and those who blindly followed his technic were seldom able to duplicate his results. "The common curse of mankind," says Shakespeare, is, "ignorance and folly." The ignorance of Lister's opponents can justly be pitied but their folly in adhering to old and established practices, their "ancestor-worship" of former teachings can hardly be condoned. Great surgeon though he

was, Simpson was the leader of the opposition to the "carbolic treatment." He denied the bacterial origin of infections and spoke of microbes as "mythical fungi," while others compared them to the belief in the aerial sylphs of the Rosicrucian philosophers. The painstaking care required in the antiseptic technic did not appeal to those whose training in pre-anesthetic times placed the greater emphasis upon speed.

Heedless of the abuse heaped upon him and encouraged only by his firm conviction in the truth of his principle as evidenced by the great success which continued to follow his treatment, Lister continued his studies. While a staunch defender of his views and ever ready to demonstrate his treatment, Lister did not enter freely into verbal polemics. The "*odium medicum*" was foreign to his nature.

New successes continued as he applied his treatment to "clean" surgical cases. Hitherto unheard of operations were performed with remarkable results. Joints were opened without fear of sepsis and viscera never before subjected to operations were exposed without fear. In 1880 after returning to his Alma Mater in London after almost forty years of absence, Lister introduced the innovation of absorbable ligatures in the form of chromicized catgut. Ligatures hitherto employed were non-absorbable and their long ends were left hanging from the wound. The introduction of absorbable sutures allowed the surgeon to cut the ends short and did away at one stroke with the clumsy practice which had been followed.

The struggle for acceptance was long and bitter. Many of his old opponents died and the young men, many of whom had been trained in Lister's Clinic, replaced them and became the chief exponents of Listerism. The "die-hards," however, continued their attacks. Now that the germ theory was more commonly believed they attacked him on the basis of priority in the use of carbolic. The French surgeon Lemaire, had actually employed carbolic acid for many years before Lister, but Lemaire had no conception of the bacterial basis of infection and his use of the acid was quite empirical and quite different even in technic from that advocated by Lister.

Long before his English brethren had recognized his worth, continental surgeons, chiefly those in Germany and France had adopted his methods and made many improvements. The prophet had no honor in his own country, but eventually his followers increased as many "who came to scoff remained to pray." The great homage accorded Lister in his later years and up to his death in 1912 is well known. He had the great satisfaction of seeing the adoption of his principle throughout the world and of receiving the gratitude of mankind.

"Simplicity of character," said Morley, "is no hindrance to subtlety of intellect," and in Lister we see a man whose quiet Quaker sobriety and demure personality little bespeak the depth of mind or the profundity of thought which was his. His were not the traits that command ready attention and make for rapid and brilliant progress. His ideals were severe, almost austere, and yet his nature showed those elements of gentleness which come only out of strength. "A warm, loving heart, and, Truth in an earnest spirit" were the ideals which he set for the medical profession. The life and work of Lister are a constant demonstration of these ideals. No praise of him is more appropriate than that given at the memorial discourse at his death.

"Of Joseph Lister's winsome personality, those speak most warmly who knew him best. It was his gentleness, above all, that made him greater. His very presence was a spiritual force. Clear-eyed and pure of soul, he cherished from earliest days that love of truth that guided him to the end. His noble passion for humanity extinguished all thoughts of self and personal fame, impelling him along the path which he steadfastly pursued till he found the secret of his search, and bestowed upon the world probably the greatest boon which science has been able to win for the physical life of mankind. Yet greater than his greatest achievement was the man himself, and the final secret of his greatness was that serene simplicity which was his most distinguished characteristic—His was the grave and thoughtful courtesy which bespoke the Christian gentleman and the earnest lover of his kind. Hence we are not surprised to learn how he stirred enthusiasm and moved men to reverence, how he gained such love and affection as rarely fall to a scientific teacher. Behind his acknowledged mastery of his science, his grave and noble face, marked by soft lines of tranquil thought, revealed a soul of singular beauty and sweetness, of high integrity, and stainless honor. That such a man, dowered with God's gift of genius,

should rise to lofty heights and achieve great things was inevitable."

"There is no greater charm for the investigator," said Pasteur, "than to make new discoveries; but his pleasure is heightened when he sees that they have a direct application to practical life." As an operator, Lister was far from brilliant, far from the foremost of his profession, but, as a founder of principles, as a benefactor of mankind, Lister is the world's greatest surgeon.

He "created anew," said Treves, "the current art of healing; he made a reality of the hope which had for all time sustained the surgeon's endeavors; he removed the impenetrable cloud which had stood for centuries between great principles and successful practice, and he rendered possible a treatment which had hitherto been but the vision of a dreamer. The nature of his discovery like that of most great movements was splendid in its simplicity and magnificent in its littleness. To the surgeon's craft it was 'the one thing needful.' With it came the promise of a wondrous future, without it was the hopelessness of an impotent past."

Modern surgery owes its very existence to Lister's achievement. Lucas-Championniere once said that there were only two periods of surgery—that before Lister and that since Lister. Fifty years ago the idea of a wound was inseparable from that of fever; today the comparative safety with which the surgeon practices his art is a marked contrast. To justly appreciate Lister's contribution to modern surgery, one needs only to view the hopeless conditions of the past.

A new era in medicine and surgery has arisen. The advent of the antiseptic principle and its resulting revolution of surgery overthrew the barriers of the past and opened fields which could scarcely have been imagined in a former day. Before Lister, one out of every three or four patients died after major operations; the mortality rate is now from two to three percent and this mortailty is now, according to Sir Berkeley Moynihan, almost entirely a mortality of delay. Before Lister, surgery was largely confined to the extremities; it now exercises its beneficient sway over every region of the body. "Even the heart," says Deaver, "is no exception, and the abdomen and pelvis, formerly considered as sacred precincts, have almost become the 'playground of the surgeon'." Many hitherto unknown lesions can now be exposed, ills and ailments formerly classed under the great sub-title "Idiopathic" are now thoroughly understood and successfully treated. The much abused but ever dangerous appendix is but one of the striking examples which might be mentioned.

The surgery of the past was the surgery of necessity. To this we may now properly add, the surgery of election. Before Lister, the only justifiable operation was one instituted as a life-saving procedure. Today we may safely subject patients to operations which not only save life, but which prolong life and promote welfare and happiness. The relief of the lame, the halt and the blind is of greater interest to the modern surgeon than the treatment of the moribund. To increase the efficiency of the worker, to maintain and augment the usefulness of the citizen are the demands which modern society now place upon surgery. The growth of industrialism has given rise to new surgical fields, "industrial surgery," "prophylactic surgery," "railroad surgery," "surgery of the reconstruction and rehabilitation of the disabled from accident and injuries" and other varieties of surgical service have come into prominence.

Fortified by asepsis, surgery has again become an art, but with a new interpretation. The development of plastic surgery, surgery upon the ductless glands and the many other advances has placed surgery in the class of the humanistic sciences. The modern surgeon has passed beyond mere duties to the individual, to the duties which he owes to his community and humanity in general.

Thus the greatly widened surgical approach increased largely the responsibilities and the usefulness of the modern surgeon. Surgery is more than what it originally meant—"chiurgy," i.e. handicraft. Besides the new element of safety, modern surgery because of Lister, can not boast of achievement.

To the man who made such unselfish efforts in our behalf, who toiled that we might gain, who achieved where others failed, surgery and humanity can never be duly grateful. His position is one of supreme greatness, his nature one of rare nobility.

To Lister we may justly apply the words written by Matthew Arnold of his father. For his was one of those

*"Souls tempered with fire,*
*Fervent, heroic and good,*
*Helpers and friends of mankind."*

# MICHIGAN'S DEPARTMENT OF HEALTH

GUY L. KIEFER, M. D., *Commissioner* · *Edited by* MARJORIE DELAVAN

The State Advisory Council of Health has adopted and authorized the publication of a Health Officer's Manual. To make the contents immediately available to physicians, chapters will be published each month in these columns.

## THE HEALTH OFFICER'S MANUAL

Effective January 1, 1928

### *Section I*

GENERAL CONSIDERATION AUTHORITY AND PENALTY

1. Act 146 P. A. 1919 provides for the appointment of a State Health Commissioner by the Governor.

The State Health Commissioner shall exercise all of the powers and be responsible for the performance of all the duties imposed by law upon the Michigan Department of Health.

2. The State Advisory Council of Health is appointed by the Governor as an advisory body.

3. The State Health Commissioner with the concurrence of the State Advisory Council of Health shall make rules and regulations to carry out the purpose of the public health laws.

4. It is the duty of all local health officers to carry out all rules and regulations of the State Health Commissioner and all special orders issued. Failure to do so constitutes misfeasance of office.

5. Any person violating any rule and regulation or any lawful order of the State Health Commissioner, shall be deemed guilty of misdemeanor and upon conviction thereof, shall be fined not more than $20, or imprisoned for not more than six months, or both.

### *Section II*

SCOPE

1. *Necessity.* It is hereby declared by the State Department of Health to be necessary and proper for the preservation of the public health to make the following rules and regulations concerning relationship with places of infection and for the apprehension and treatment of persons who may be affected with or who shall have been exposed to any infectious, contagious or communicable disease.

2. *Minimum Requirements.* It is hereby declared by the State Department of Health that these rules and regulations are to be the *minimum requirements* for the safeguarding of the public health within the state.

3. *Power to Make Additional Rules.* Local Boards of Health are hereby authorized and empowered to make such additional rules and regulations for the care and control of communicable diseases as may be necessary, provided they are not in conflict with these basic rules and regulations and are not contrary to the best public health practice.

4. *Investigation of Suspected Cases.* Whenever a local Board of Health receives a report of a case of a communicable disease from a person who is not a physician or receives a report from a physician that a certain case is suspected of being a contagious disease, the said Local Board of Health shall cause an investigation to be made to determine the true nature of the disease. This investigation may be made by a physician or by a medical representative of the State Department of Health.

5. *Reports to the State Department of Health.* Local health officers are required to forward all reports of the occurrence of communicable disease to the State Department of Health, immediately. This has been interpreted by the courts to be within the following twenty-four hours.

6. *Removal.* Whenever a local Board of Health allows the removal of a case of communicable disease while in an infectious stage, from their jurisdiction, this fact must be reported to the State Department of Health.

7. *Repeal of Previous Rules and Regulations.* All rules and regulations of the State Department of Health promulgated prior to this date which are in conflict in whole or in part with any of these rules and regulations are hereby repealed insofar as they conflict with these rules and regulations.

8. *Provision for New Rules and Regulations.* All rules and regulations issued by the State Department of Health at a date subsequent to the date of these rules and regulations shall amend or modify these

rules and regulations on every point of conflict.

9. For the purpose of these rules and regulations the following diseases are declared to be reportable:

Actinomycosis
Acute Infectious Conjunctivitis (ophthalmia neonatorum)
Ankylostomiasis
Anthrax
Cerebrospinal fever (meningococcus meningitis)
Chancroid
Chickenpox
Cholera (Asiatic)
Dengue fever
Diphtheria and membranous croup
Dysentery (amoebic or bacillary)
Encephalitis Lethargica (Sleeping Sickness)
Erysipelas
German Measles
Glanders
Gonorrhea
Influenza (Epidemic only)
Leprosy
Malaria
Malta fever (See Undulant fever)
Measles
Mumps
Paratyphoid fever
Plague
Pneumonia (lobar and broncho)
Poliomyelitis (acute anterior)
Rabies
Rocky Mountain fever
Scarlet fever (scarlatina)
Septic sore throat
Smallpox
Syphilis
Tetanus
Trachoma (granular conjunctivitis)
Trichinosis
Tuberculosis (all forms)
Tularemia
Typhoid fever
Typhus fever
Undulant fever (Malta fever)
Vincent's Angina
Whooping cough
Yellow fever

The following contagious and preventable diseases should be supervised and controlled and may be excluded from school but need not be reported:

Impetigo
Favus
Tinea tonsurans (Ringworm)
Scabies (Itch)
Pinkeye
Pediculosis (Lice)
Other contagious skin conditions

*Section III*

REPORTING

(a) *Definition.* For the purpose of these rules and regulations a case of any of the diseases mentioned in Section 2 may be said to be *reported* when the name of the person, address, age, color, sex, together with the name of the disease existing or suspected is given in *writing* to the Local Health Officer (or State Department of Health, if a venereal disease) immediately after seeing such a case. Court decision interprets the word "immediately" to mean "within the following twenty-four hours." The report shall be properly dated and signed, giving the address of the physician or other person so reporting.

(b) *New cases in Home.* Every new case of a reportable communicable disease developing in a family where one already exists *must be reported.* All these reports must be forwarded by local health officers to the State Department of Health immediately.

(c) *Special Reports.* For reporting *Chancroid, Gonorrhea,* or *Syphilis,* special blanks are obtainable from the State Department of Health which must be filled in and submitted as the official report of the case.

(d) *Who Must Report. Cases must be reported* as described above by the following persons provided that no person shall be prosecuted for not reporting a case that has already been reported:

1. Physicians and dentists must report all cases known or suspected by them of having any of the diseases mentioned in Section 2 of these rules and regulations.

2. All persons other than physicians, must report as described above all suspected cases and all places where they have reason to believe there is a case of communicable disease. Among others this includes:

(a) Parents and guardians.

(b) Superintendents, principals, and teachers of all public and private schools.

(c) Nurses, whether engaged in private duty, school, public health, or industrial work.

(d) Keepers of hotels and lodging houses.

(e) Superintendents of public or private hospitals, clinics, dispensaries, asylums or jails.

(f) Owner or manager of any dairy farm or other place where dairy products are handled or offered for sale, must report all possible cases among their employes or the families of these employes.

(g) Licensed embalmers must report all cases where they are called upon to embalm a body when the death certificate certifies that the primary or contributory cause of death was one of the diseases mentioned in Section 2.

It is the intent and expectation of these rules and regulations that every case of communicable disease will come to the attention of someone who will be legally responsible for the reporting of the case.

By requiring suspected cases to be reported the same as known cases, the possibility of mild, missed or abortive cases not receiving attention is minimized.

*Summary.* What is to be reported? All cases and suspected cases of the diseases listed in Section II.

When? "Immediately" has been defined by the courts to mean "within the ensuing 24 hours."

How? Reports can only be made officially in writing.

Where? To the local health officer. Venereal diseases must be reported directly to the State Health Department.

Who? Any physician who sees the case or the layman who has reason to believe

of the existence of a case or a suspected case.

PLACARDS

(a) *Definition.* For the purpose of these rules and regulations the word "placard" shall mean that a card at least seven by eleven inches in size, bearing in large letters the word "quarantine" or "warning" shall be conspicuously placed on or near all doors leading to and from the quarantined area.

(b) *Quarantine Placard.* A quarantine placard shall be a yellow card which shall read essentially as follows:

QUARANTINE

No one shall enter or leave these premises, except as provided by the rules and regulations of the Michigan Department of Health.

Violation of this rule is punishable by law.

This card is to be used in cases of Diphtheria, Scarlet Fever, Smallpox, Poliomyelitis and Meningitis.

It is a misdemeanor punishable by law to remove this placard without authority of the local Health Officer.

.....

Local Health Officer.

(c) *Warning Card.*

A warning card shall be a red card which shall read essentially as follows:

WARNING

This card establishes an Isolation as defined by the Michigan Department of Health.

This card is used on the home of cases of Measles, Whooping Cough, Chickenpox, Mumps and German Measles and Diphtheria Carriers and persons exposed to a quarantinable disease.

It is a misdemeanor punishable by law (1) to allow any child susceptible to this disease living in this house to return to school while this placard is posted, or (2) to remove this placard without authority of the Local Health Officer.

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Local Health Officer.

*Purpose.* The local board of health has the responsibility of informing the public where any menace to health exists. This responsibility is met by the use of placards announcing such facts to the public.

*Responsibility.* The responsibility of putting up and taking down placards rests upon the local board of health. Any improper use or unauthorized removal of a placard is punishable by law.

*Kinds.* One kind of a card is used to announce a quarantine and another to show where a case of measles, whooping cough, mumps, chickenpox or German measles resides, a diphtheria carrier or a person exposed to a quarantinable disease.

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THE NEW "TAXICAB DRIVERS LAW"

The physical examination of all persons driving autos carrying passengers for hire is required by Act 309 of the Public Acts of 1927. The pressure for legislation of this kind came to the legislature because of such regrettable occurrences as accidents at railroad crossings with busses loaded with children on their way to school.

It has happened in the past that certain auto accidents have been the direct result of early tabes. It was for this reason that the clinical and laboratory examinations for syphilis were required by the act. The act reads, "No certificate shall be issued to any applicant whose vision shall be less than 50 per cent of normal in each eye, whose hearing shall be less than seventy-five per cent normal and unless such applicant shall be free from clinical and laboratory signs or tests of syphilis or any other disease of the nervous system and shall be free from any communicable disease dangerous to the public health."

For the purpose of carrying out the provisions of this act the State Health Commissioner is required to designate any necessary number of registered and qualified physicians for the purpose of examining the applicants. *The State Health Commissioner has appointed the entire enrollment of each County Medical Society of the state.* This makes each member of each County Medical Society a direct representative of the Michigan Department of Health for the purposes of carrying out this act.

The blanks and mailing cases for the laboratory containers can be had by addressing the department, and this work will be expedited by suitable additions to the department staff. After the containers and the blanks for the physical examinations have been received by the physician, the physicial examination should be made and blood drawn for serological tests. The blood should be sent to the laboratory in the usual way and the physical examination blank held at the physician's office until the report of the blood specimen is received. Then the laboratory blank can be attached to the physical examination blank and the whole forwarded to the Michigan Department of Health.

The fee for the physical examination is to be paid by the chauffeur who is examined.

—Don M. Griswold, M. D., D. P. H.
Deputy Commissioner.

### ORGANIZATION OF STUDY CLUBS

A recent addition to the activities of the Bureau of Child Hygiene and Public Health Nursing of the Michigan Department of Health consists in the organization of study clubs on prenatal, infant and preschool care. Forty clubs have already been organized in Gogebic, Menominee and Lapeer counties, and it is hoped that other counties will be added. In Gogebic and Menominee counties, Parent-Teacher associations have undertaken the study, but in Lapeer county the groups consist of interested women regardless of organization.

The Michigan Mothers' Manual is given to each club member to use as a text book, and outlines and additional literature are furnished to the leaders. The study is divided into six lessons, and there is a leader for each lesson. Local physicians in several places have agreed to discuss the lessons on prenatal and infant care, and in one instance the physician has agreed to take charge of all six lessons. Reports already received of the attendance at these classes show a very gratifying response, and some group leaders have sent for more literature for new members.—L. R. S.

### POLIOMYELITIS

Beginning November 16, the number of cases of poliomyelitis occurring throughout the state began to decrease very markedly. This is as was predicted, as the number of cases falls rapidly, ordinarily, with the onset of cold weather. The largest number of cases this year occurred in September when 98 were reported. October followed with 91 and in November 34 cases were reported. During the first ten days of December there have been eight more cases.—P. F. O.

### REGISTRATION NUMBERS OF MICHIGAN LABORATORIES HANDLING PATHOGENIC ORGANISMS

(Additions to December 1, 1927)

| Registration No. | Location | Name of Laboratory |
|---|---|---|
| 78 | Albion | Albion College, Department of Biology |
| 79 | Alma | Alma College, Department of Biology |
| 74 | Ann Arbor | Hygienic Laboratory, University of Michigan |
| 75 | | Cowie Hospital Laboratory |
| 82 | | Michigan Biological Supply Co. |
| 70 | Battle Creek | Nichols Memorial Hospital |
| 73 | Detroit | Harper Hospital |
| 65 | | Parke Davis & Co. |
| 67 | | Robison Laboratories, Inc. |
| 76 | | Detroit Clinical Laboratory |
| 77 | Grand Rapids | Grand Rapids Junior College, Dept. of Biology |
| 80 | Holland | Hope College, Department of Biology |
| 84 | Jackson | Foote Hospital |
| 81 | Kalamazoo | Upjohn Company |
| 69 | Lansing | St. Lawrence Hospital |
| 72 | Laurium | Calumet Memorial Hospital |
| 68 | Mt. Clemens | Dr. Persson's Laboratory |
| 66 | Petoskey | Petoskey Hospital |
| 71 | Pontiac | City Hospital |
| 83 | Roseville | F. T. Zieske, M. D. |

### PREVALENCE OF DISEASE

November Report
Cases Reported

| | October 1927 | November 1927 | November 1926 | Av. 5 Years |
|---|---|---|---|---|
| Pneumonia | 239 | 361 | 363 | 371 |
| Tuberculosis | 523 | 453 | 242 | 391 |
| Typhoid Fever | 78 | 62 | 50 | 94 |
| Diphtheria | 403 | 496 | 710 | 817 |
| Whooping Cough | 442 | 389 | 492 | 416 |
| Scarlet Fever | 489 | 815 | 970 | 1,037 |
| Measles | 140 | 526 | 324 | 511 |
| Smallpox | 38 | 72 | 83 | 143 |
| Meningitis | 8 | 12 | 3 | 9 |
| Poliomyelitis | 91 | 34 | 6 | 24 |
| Gohorrhea | 1,057 | 725 | 912 | 866 |
| Syphilis | 1,367 | 1,099 | 1,308 | 1,013 |
| Chancroid | 9 | 14 | 10 | 10 |

### CONDENSED MONTHLY REPORTS

Lansing Laboratory, Michigan Department of Health
November, 1927

| | + | — | +— | Total |
|---|---|---|---|---|
| Throat Swabs for Diphtheria | ..... | ..... | ..... | 1029 |
| Diagnosis | 31 | 463 | ..... | ..... |
| Release | 66 | 132 | ..... | ..... |
| Carrier | 4 | 310 | ..... | ..... |
| Virulence | 21 | 2 | ..... | ..... |
| Throat Swabs for Hemolytic Streptococci | ..... | ..... | ..... | 667 |
| Diagnosis | 121 | 232 | ..... | ..... |
| Carrier | 43 | 271 | ..... | ..... |
| Throat Swabs for Vincent's | 20 | 470 | ..... | 490 |
| Syphilis | ..... | ..... | ..... | 5895 |
| Kahn | 847 | 5008 | 37 | ..... |
| Wassermann | ..... | 2 | 1 | ..... |
| Darkfield | ..... | ..... | ..... | ..... |
| Examination for Gonococci | 192 | 1108 | ..... | 1300 |
| B. Tuberculosis | ..... | ..... | ..... | 350 |
| Sputum | 72 | 288 | ..... | ..... |
| Animal Inoculations | 8 | 47 | ..... | ..... |
| Typhoid | ..... | ..... | ..... | 188 |
| Feces | 7 | 68 | ..... | ..... |
| Blood Cultures | 4 | 29 | ..... | ..... |
| Widal | 10 | 65 | ..... | ..... |
| Urine | ..... | 5 | ..... | ..... |
| Dysentery | ..... | ..... | ..... | 43 |
| Intestinal Parasites | ..... | ..... | ..... | 23 |
| Transudates and Exudates | ..... | ..... | ..... | 166 |
| Blood Examinations (not classified) | ..... | ..... | ..... | 143 |
| Urine Examinations (not classified) | ..... | ..... | ..... | 325 |
| Water and Sawage Examinations | ..... | ..... | ..... | 628 |
| Milk Examinations | ..... | ..... | ..... | 93 |
| Toxicological Examinations | ..... | ..... | ..... | 8 |
| Autogenous Vaccines | ..... | ..... | ..... | 6 |
| Supplementary Examinations | ..... | ..... | ..... | 340 |
| Unclassified Examinations | ..... | ..... | ..... | 434 |
| Total for the Month | ..... | ..... | ..... | 12193 |
| Cumulative Total (fiscal year) | ..... | ..... | ..... | 61343 |
| Decrease o fthis month last years | ..... | ..... | ..... | 166 |
| Outfits Mailed Out | ..... | ..... | ..... | 16883 |
| Media Manufactured, c.c. | ..... | ..... | ..... | 285811 |
| Antitoxin Distributed, units | ..... | ..... | ..... | 50356000 |
| Toxin Antitoxin Distributed, units | ..... | ..... | ..... | 177500 |
| Typhoid Vaccine Distributed, c. c. | ..... | ..... | ..... | 1480 |
| Silver Nitrate Ampules Distributed | ..... | ..... | ..... | 3088 |
| Examinations Made by the Houghton Laboratory | ..... | ..... | ..... | 1489 |
| Examinations Made by the Grand Rapids Laboratory | ..... | ..... | ..... | 5852 |

# University Hospital Clinic

*December 17, 1927*

In Ann Arbor, Friday and Saturday, November 18th and 19th, a clinic was held under the auspices of the Post Graduate Department of the Medical School and the Michigan State Medical Society. This clinic was attended by about 300 of the leading practitioners from the entire state, and it was held in the new University of Michigan Hospital. The Galens, an honorary society, among the medical students, volunteered as ushers and conducted the visiting physicians throughout the hospital. The program began at 9 o'clock Friday morning in the numerous operating rooms and laboratories.

The following clinics were held in the operating rooms on the third floor.

In the Department of Surgery, Dr. Cabot did a cholecystectomy and one stage prostatectomy. Dr. Coller did a stenosing ulcer of the duodenum and a goitre (steal). Dr. Peet did a linear craniectomy and two cases of oxycephaly. Dr. Alexander performed a phrenicectomy for tuberculosis, an extrapleural thorocoplasty and a chronic empyema. Dr. Eberbach operated on a patient for cancer of the prostate. In the gynecology operating rooms, Dr. Peterson did a panhysterectomy and a plastic operation. In ophthalmology, Dr. Parker did four cataract removals under local anesthesia, the removal of a pterygium, an enucleation and a plastic. In the oral surgery operating rooms, Dr. Lyons first did a plastic operation on a small girl for a hare lip and this was followed by another plastic operation for cleft palate. In the otology operating rooms, Dr. Furstenberg and Dr. Canfield did six tonsillectomies, a bilateral antrum puncture, a simple left mastoidectomy, a left radical mastoidectomy, and a laryngectomy.

Members more interested in diagnostic methods and internal medicine had their choice of several demonstrations Friday morning. In internal medicine, Dr. Newburgh held a demonstration from 12:00 to 1:30 o'clock in the research laboratories on the basement floor, of modern aparatus used in the study of nutritional problems. All visiting physicians were shown the new pendulum balance for the accurate weighing of patients on reduction diets; the various gas exchange machines and the methods used in this clinic for the study of all problems of metabolism. Dr. Newburgh and Miss Harrington also gave a demonstration and a discussion of the various diets used in the treatment of diabetes mellitus and obesity. All of the various diets were made up and placed on trays so that each physician could see how much food and what type of food each patient got for each meal.

Dr. Wilson gave a demonstration of the equipment and apparatus used in modern electrocardiographic studies and this demonstration was followed by informal discussion. At the Simpson Memorial Institute, from 10:30 until 12 o'clock, Doctors Sturgis, Isaacs and Smith, by demonstrations and discussions, gave to all visiting physicians the differential diagnosis and treatment of the various anemias. All physicians were also shown throughout this new research institute. The Department of Roentgenology and Radiology gave two demonstrations between 10:30 and 12 o'clock. The first, conducted by Dr. Hickey, was of numerous plates showing the use of the orthodiagraph in cardiac measurements of non-tuberculous disease of the chest and of numerous gastric cases. The second demonstration was given by Dr. Ernst A. Pohle, who conducted the physicians through the Roentgenology Department and gave a demonstration of dessication and electrocoagulation in the treatment of malignant disease and the clinical application of diathermy. Following the morning session, all visiting physicians were invited to a luncheon from 12:30 to 2 o'clock at the University Hospital.

The afternoon session opened at 2 o'clock, first, with a clinical pathological conference conducted by Doctors A. S. Warthin and Carl V. Weller. Cases of carcinoma of the blood-forming organs, empyema of the lung, and cancer of the lung were presented. These were discussed from the medical, surgical, and roentgenological aspects, and then finally the pathological study was given. At 2 o'clock in the hospital amphitheatre, Dr. Carl E. Badgley presented a clinic on the treatment of delayed union and ununited fractures. At 2:30, Dr. Frederick Coller gave

a clinic on the treatment of hyperthyroidism. From 3 to 5 o'clock, a combined clinic was held by Doctors Newburgh, Camp, Wile, Hickey, Warthin and Peet, on endocrine disease. The first case was presented by Dr. Camp and was a very definite case of acromegaly. The metabolic aspect of this case was then discussed by Dr. Newburgh; the dermatological phase by Dr. Wile; the roentgenological studies by Dr. Hickey, and finally, the surgical possibilities of such cases were discussed by Dr. Peet. The next case was that of myxoedema, which was presented by Dr. Newburgh and discussed from the various aspects by Doctors Camp, Hickey, Warthin and Peet. The clinic was concluded by the presentation of a case of crypt orchidism by Dr. Wile, and the effect of such a condition was discussed from the metabolic standpoint by Dr. Newburgh, and the neurological and psychological by Dr. Camp. The pathological changes expected to be found was discussed by Dr. Warthin.

The attending physicians were the guests of the Michigan State Medical Society at luncheon at the University Hospital and were entertained at dinner at the Michigan Union by the Department of Post Graduate Medicine. Following the dinner, Dr. W. D. Henderson, of the Department of University Extension, gave a most interesting address, which was followed by a round table discussion on past and present medical problems by the members attending the dinner.

On Saturday morning, in the hospital amphitheatre, Dr. D. C. Balfour, of the Mayo Clinic, gave a very interesting clinic on surgical diseases of the stomach. The meeting officially closed at the end of this clinic and a great many of the visiting physicians stayed for the Michigan-Minnesota football game held that afternoon. It was, indeed, a highly exciting game and saw the passing of two rival captains who will go down as two of the best football players in the history of Michigan and Minnesota.

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### SYNOPSIS OF AN ADDRESS

Dr. W. D. Henderson

Michigan Union, Ann Arbor, November 18, 1927

Ladies and Gentlemen:—During the past twenty years or more I have had an opportunity of speaking in practically every city, town, village and hamlet in the state. This experience has brought me into contact with people of every grade and position. I believe I am safe in saying that I know the mind of the people of Michigan as well as, or possibly better, than any other member of our faculty. During these years I have been an interested student of the changes which are going on about us—changes involving the economic, social and educational life of our state. I have been especially interested in observing the attitude of mind with which the people of Michigan as a whole approach certain problems. I wish to speak tonight particularly of three tendencies which I think most students of public affairs have observed.

The first of these relates to the new educational movement which is known as adult education. The term, "adult education," as I am using it, applies in a general way to those supplementary educational activities which are carried on by people who, while primarily engaged in the business of earning a living, are disposed to devote a part of their leisure time to study, either along vocational or cultural lines.

You gentlemen who are attending this conference are engaged in a phase of adult education. We used to think of education as coming to an end on the day of graduation. We no longer look upon it in this way. People everywhere are beginning to come to a realizing sense of the fact that education is a continuing process.

The second point to which I refer is the growing interest in the subject of health on the part of our people. One of the most interesting phenomena of our modern educational movement is the extraordinary interest manifested by people everywhere in matters that relate to health. We have, as a people, apparently just discovered that the body is a machine—a most wonderful machine, and as such, requires attention and care. In health education we are just entering the edge of a new day. As an example of this interest in all matters relating to health, we have but to note that practically every first class daily in this country feels under the necessity of carrying on a health column. We have our Bradys, Copelands, Evanses and others too numerous to mention. The fact that papers are willing to pay cold cash for this health column copy is evidence that the people read this material and that editors consider it worth while as a matter of news.

During the past four or five years our Joint Committee on Public Health Education has done a piece of pioneer work in this state. I believe Michigan was the first state to organize such a committee. The function of this organization is to present

the fundamental facts of modern, scientific medicine for the purpose of building up sound public opinion relative to the question of public and private health. It is concerned in bringing the truth to the people, not in supporting or attacking any school, sect, or theory of medical practice. It aims to send out teachers, not advocates.

Last year we gave 550 health lectures throughout the state, a large part of these being given in connection with high school programs. It is worthy of note that in every one of the ninety-one schools where these health programs were carried on last year, the superintendents or principals connected therewith have asked for a continuation of the work this year. In this connection I wish to express my appreciation for the splendid service rendered in connection with our health program by the physicians of the state, members of the Dental Society, and others interested in health work.

The third and most significant statewide movement, so far as the social and civic life of the people is concerned, is that known as the Community Center movement. Within the past few years, there has arisen in this state, as in many others, a form of activity looking toward the organization of community center activities. Michigan has the distinction of being the first state in this country in which there was organized a successful community center activity, comprising an entire county. I am referring here to the Hesperia community center movement in Newaygo County, a project which has been carried on continuously for something like thirty-five years.

The community center activities to which I refer represent attempts on the part of certain public-spirited men and women, especially in the smaller centers of the state, to create a public sentiment in favor of social, intellectual, and civic betterment. The movement is in the main altruistic in its ideals. The primary agencies through which such activities function are the schools and community churches. In some centers this movement has gone forward with remarkable success, but in far too many cases it has lagged, due largely to the need of leadership and direction. I have a feeling that every college and university graduate has a very definite responsibility in connection with the social, civic, and intellectual activities of his community. His first business, of course, is to master the details of the calling which he has chosen, be it teaching, preaching or the practice of medicine. If he has a true appreciation of the opportunities which are his by virtue of his training, he cannot escape the responsibility which rests upon him to take some part in this community center movement, whether he find himself located in a city, small town, or in country places. All too frequently, doctors have kept themselves aloof from such civic and socializing activities. They have felt that their energies should be directed altogether to the practice of their profession. What man, let me ask, in a community is more vitally in touch with the life of the people than is the physician? He is looked upon as one who has had the advantage of a scientific training, and, in general, his word carries great weight. I believe, gentlemen, that it is possible for you to render to your various communities a most effective service in connection with these community activities. Here is an opportunity to come into contact with your environment in an entirely new way, an opportunity not only to play the part of the healer, but also that of the teacher and counsellor as well. If we find, as some state, that people are inclined to turn away from the medical profession and to follow after cults and fads, I am sure that the doctors themselves are in some measure to blame. So far as community activities are concerned, we are entering a new stage in our civic and social life. People have awakened to the possibilities of adult education. They are interested in public health in a way that is not only new, but extremely significant. Are we to expect that only teachers, preachers, and public-spirited business men are to be the active agents, and later on, the directors in this new movement? I hope not. I believe that every doctor has a part to perform. His business, as I see it, is not only with the writing of prescriptions and performing operations, but also in assisting in the direction and control of the intellectual, social, civic and health life of his community.

May I repeat: the doctor should be not only a healer, but a teacher as well.

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### ADDRESS

James D. Bruce, M. D.

Mr. Chairman, Ladies and Gentlemen: I approach the subject of extension work in Medicine with a good deal of trepidation, not only on account of its somewhat nebulous state at the present time, but also on account of the presence of a man who has carried the extension idea along other

educational lines to such a high point of efficiency and of value to our state. A further reason for my hesitancy in the discussion of a topic having to do with medical education, is the fact of my comparatively recent association with problems of this character. As one recalls the changing viewpoints and opinions of the last few years, opinions that were founded upon seemingly substantial information, one may well hesitate to outline a course that involves more than the very immediate future.

I had the privilege some time ago of reading a letter from a man who always has been my ideal physician, the late Theodore McGraw, for many years Dean of the Detroit College of Medicine. Great changes had been taking place in methods of medicine teaching and in educational standards with the result that for years, one after another of the more poorly equipped and meagerly provided for medical schools, had been closing their doors.

Dr. McGraw, who had for many years been a leader in medical education in this country and more responsible than any other for the prestige of the Detroit College of Medicine, came to the conclusion that that institution had served its usefulness and that the University of Michigan Medical School was amply able to take care of the educational needs and responsibilities of this state. With the consent of his faculty and board of trustees, he offered the buildings and all of the physical equipment, together with the use of all the clinical facilities at their disposal, to the University of Michigan. At the same time, he advanced the opinion that the clinical opportunities at the University Medical School and Hospital were altogether inadequate for the successful teaching of medicine and that they never would be ample and advised that the clinical years of the University Medical course be removed to Detroit where ample material was available.

Here was a great man, personally familiar with the educational needs of his time and community, advancing an honest opinion with the information that he had at hand. Notwithstanding that Dr. McGraw's opinion was shared by a great many of those concerned with medical education in Michigan, certain developments prevented the acceptance of the offer and the Detroit College of Medicine carried on and under the able administration of its present distinguished dean, has taken high place and done a magnificent work and filled a great need in the education of doctors in Michigan and today stands relatively higher in the educational world than ever in its history. In Ann Arbor, contrary to the best opinion of those days, there has been developed clinical material entirely adequate for the successful teaching of medicine.

In 1904, there was graduated 5,747 students from the 166 schools then in operation in this country. It was considered quite generally the number of medical schools and supply of physicians was at this time greater than the demand. The rising standards, together with the classifying of medical schools, soon brought about a most remarkable change. One by one, the more loosely constructed and poorly supported schools have either joined up with state universities, amalgamated with other schools for mutual strengthening, or dropped out of the race.

In the year 1926, 3,962 were graduated from 78 schools, only 69 of which gave the full four years course. Not only have the number of schools been cut down and the number of graduates greatly reduced, but a definite overcrowding of the remaining schools makes it extremely difficult to offer a well-balanced course. The specialties, together with the emphasis placed upon research, have so divided the issue as to give grave concern for the perpetuation of that group so long regarded as the backbone of the profession,—the general practitioners.

With the broadening of the medical course, incident to increasing knowledge, it seems undesirable to increase the number of graduates from the schools now in operation. Carefully worked out statistics show that 129,000 physicians now under 65 years of age in this country, will, at the present trend of production, drop to 114,000 in 1945 and this in the face of an increasing population that will add 50 per cent to the responsibilities of physicians at that date. With a 30 per cent reduction in our medical graduates and 116 per cent increase in the cults in the past twenty years, the proper care of the sick will show increasing difficulties unless this problem is carefully considered and wisely provided for.

Last year, approximately 1200 candidates applied for admission to the Detroit College of Medicine and the University Medical School. Of these, it is estimated that some 200 had made applications elsewhere. However, the University Medical school accepted, in round numbers, 200, and the Detroit College of Medicine, 125.

Almost 700, who seriously hoped and expected to gain admission, were rejected.

This is neither the time nor the place to discuss all the problems that arise through this situation. The problem of selection out of this large number is one of great difficulty and what becomes of those whose desire it is to enter medicine but to whom the opportunity is denied, is a matter of concern. Aside from the question which concerns the supply of physicians for the coming years as determined by the very obvious trend of medical education, there arises another problem and that is the expediency of first rate schools like the Detroit College of Medicine and the University Medical School undertaking the education of almost twice the number of students that, according to very good opinion, can be done to the advantage of the student himself, to those he will later serve, and to the reputation of the school itself.

The functions of a medical school and particularly of a tax-supported medical school such as ours, may, I believe, be divided into three. First, the training of doctors. To this, the state has added a second obligation, the care of patients. Second, the development of research and the training of teachers for the various sciences making up medicine. Third, provision whereby the graduate may maintain a continued contact with medical progress to the end that he continue as a student of medicine always.

Thirty and forty years ago, when the sum total of medical knowledge was relatively small, and before the relationship of the collateral sciences had been brought into the prominent positions they now occupy, these primary functions were relatively easy of fulfillment. Discoveries in the fields of sicence, with their many interrelations, have greatly complicated the teaching problem and today, even with the added years in the curriculum and greatly increased personnel, the business of turning out a well-rounded graduate is becoming increasingly difficult. The necessity for adequate laboratory training is apparent and students profit greatly through association with trained research workers. Liberal provision must also be made for the specialties in the regular undergraduate curriculum but the relation of these problems to the practical clinical side and their satisfactory correlation is still difficult of fulfillment.

The point I have particularly in mind is that the field of Medicine has become so broad and the various scientific bypaths of research, investigation, and teaching are so alluring that the tendency to wander from the primary medical school function, which is the making of doctors, whose place in society is primarily the care of the sick and the prevention of disease, has been too often lost sight of. That the number of our medical schools has been reduced to a minimum, no one doubts. Notwithstanding their overcrowded condition, the question of the future supply of physicians deserves consideration. The constantly increasing tendency toward the development of specialties and the gradual broadening of the curriculum add to the difficulties of the teaching problem. In addition to these considerations, we must not lose sight of the fact that the cults, both in kind and number, are increasing very rapidly and there seems much evidence that they are being regarded with increasing favor by the public. The consideration accorded them both in judicial decisions and in legislative enactment gives further emphasis to this statement. These problems have not arisen overnight and do not call for snap-shot remedies.

A greatly enlarged personnel in both our existing medical schools, together with a full year's teaching program, (four quarters system), while helpful in rounding out our present teaching programs, will not make possible an increase in our graduates.

Lowering the requirements for admission and shortening the course has been offered as a remedy for the scarcity of doctors in the rural communities. That this is not the answer to this problem is borne out by Pearl's painstaking investigation, in which he finds that the man with a college degree is relatively as likely to settle in a rural community as is the man slipping by with just the bare requirements for admission. In fact, the more poorly equipped he is, the more apt we are to see him finding his richest returns in the more populous centers.

While there will be other and possibly more adequate solutions of the many problems suggested as time goes on, a very simple and obvious one appears near early fulfillment.

By increasing the efficiency of our profession, by placing within its reach opportunities for developing greater accuracy in diagnosis and improvement in technic, our range of usefulness becomes wider, more people will be served and better served. The responsibility of increased

practice and one that requires greater technical skill adds to our interest in our work, to the importance of our position in our communities, and, incidentally, to our income. By increasing the ability to do more and better work, the smaller towns and cities become increasingly attractive and it does not seem unreasonable to think that they may again become centers of medical service.

If society is to be adequately served and if the regular medical profession is to continue to care for and to lead the way in matters of both private and public health, obviously it must be kept in contact with the workshops of medical progress. To this end, the Board of Regents has, as many of you know, complied with the recommendation of Dean Cabot and President Little in the establishment of a Department of Post Graduate Medicine in the medical school. This action on the part of the university was due largely to the solicitation of the State Medical Society that its members be accorded the privilege of medical school contacts after graduation. That the university has recognized the need for this work and is making provision for its maintenance is a matter of congratulation to both the profession and to the university.

Following the lead of the splendid work the State Medical Society has begun through its Post Graduate Conferences, it seems to us that a great deal more extramural teaching may be gotten under way in the near future as well as the development of institutional courses.

While plans are under discussion with our faculties and with men throughout the state, I do not feel in a position to make an authoritative statement at this time regarding a definite program. It may be said, however, that our plans involve the utilization to the fullest of our available resources for the benefit of our state membership. A large number of men throughout the state, already participating in the Post Graduate Conferences of the State Medical Society, have signified their willingness to join in this program.

In the larger cities and in Detroit especially, I am looking forward to Post Graduate teaching on a scale which the character of their medical men and the quantity of their clinical material would seem to justify. Both Detroit and Ann Arbor have been tardy in assuming the responsibility for the definite program in Post Graduate teaching, but with the rapidly increasing hospital facilities in Detroit and in other cities throughout the state and the greater opportunities incident to the recent building extensions in Ann Arbor, there seems no good reason for further delay.

There are those who believe that a fully equipped Post Graduate School with adequate centralized staff, laboratories, and hospital connections, should be our objective. It does not seem to me that this is a matter for special consideration at this time.

Our immediate duty is the correlation and utilization of our present resources. This is a broad co-operative movement in which every doctor in Michigan is a working partner. The measure of success will depend upon the sincerity and intelligence with which we approach the problem and the zeal with which we apply ourselves to the task.

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### ADDRESS

Andrew P. Biddle, M. D.

Mr. Chairman, as I am deeply interested in much of what you have said, may I add a few words in regard to one of the subjects you have brought to our attention, namely Post Graduate instruction through the establishment of a Post Graduate Medical School? I want it understood, however, that I am not speaking officially as Chairman of the Committee on Medical Education of the Michigan State Medical Society, nor as representing any school or hospital in Detroit, but am presenting simply my own views, formed after years of earnest thought on the subject with the hope that a practical, working solution may be found. That the profession of Michigan desires and appreciates Post Graduate instruction is attested by the presence of so many of us here tonight after a day of witnessing the excellent program presented by the Faculty of the Medical School.

My undergraduate study consisted of three years of collegiate work with two years of hospital internship. My years of practice are now more than forty. It is readily seen that the undergraduate work is merely a preparatory course which permits one to get an insight into the science and art of medicine and to be licensed to practice. Were all of us to stop at this threshold, no progress could be made and the wonderful advancement of this science and art during the last fifty years would never have been witnessed.

From what you have said, Mr. Chairman, I am fully convinced that the situa-

tion now offers a working basis. The essentials to the launching of a Post Graduate School and to its continuance rest first on an organization with years of experience in teaching; secondly, on a faculty composed of medical men with large clinical experience ,and the ability and desire to teach; and, thirdly, on proper facilities for instruction. In Ann Arbor, with its university with a prestige second to none in this country, with its years of experience in extension division work we have the first essential fulfilled, a centralized, organized body ready to assume responsibility and ready to co-operate. In Ann Arbor, in Detroit, and throughout the state we have the men from whom the second essential, an experienced faculty, can be drawn; and thirdly, we have in Detroit an abundance of clinical material, were such material brought under organization. I am firmly of the opinion that any faculty chosen from Ann Arbor or Detroit should be distinct from the undergraduate teaching body as such, but should be extramural, to which other teachers and clinicians should be invited. We should take advantage of the experience of the Graduate School of the University as well as the newly organized Department of Post Graduate Medicine, which has been authorized by the Board of Regents in response to the recommendation of the State Medical Society. I believe that a committee of these bodies should invite cooperation with one appointed by the profession of Detroit, preferably the Wayne County Medical Society, in order that the profession might be thoroughly represented in the details which must be attached to the inauguration of this work.

As I vision it, the prestige and power of our great University should be the foundation stone and the background of this endeavor and from here should arise the initiatory and propelling force. Here, in my opinion, should be taught, not only clinical subjects, but within its great laboratories such fundamental subjects as Anatomy, Pathology and Bacteriology. And in Detroit, with its wealth of clinical material, its splendid hospitals, and its varied teaching facilities, should be established extensive Post Graduate teaching. I am entirely in accord with the plan as outlined by Doctor Bruce, which, if I understand it rightly, does not have for its immediate objective a Post Graduate Medical School, but suggests that we proceed to correlate all our resources for the advancement of medical knowledge and in the interest of the state.

I understand that such a course has received the approval of the President of the University and has been accepted by the Regents, and am sure, after the details have been ironed out, will be sanctioned and aided by the profession of Detroit.

Such a school, fostered by the State Medical Society, the University, and Detroit, offers Post Graduate instruction second to none. It should in time offer definite instruction to the physician desiring to take up one of the specialties; should be empowered by law to give recognition for the work done; and would reflect the earnest desire of the profession that our institutions of learning and our vast clinical material be placed at the disposal of the profession at large for the advancement of medicine and surgery.

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### DR. McLEAN FAVORS GRADUATE MEDICAL STUDY

Dr. Angus McLean was called upon to address the meeting. The doctor, who has been for some years a member of the Board of Education of Detroit, was enthusiastic in the matter of graduate medical education. The Detroit College of Medicine and Surgery is a unit in the educational forces of Michigan's metropolis. Dr. McLean went on to tell how much Detroit spent annually in education. Of the sum mentioned, approximately $33,000,000, only about $7,000,000 went for new buildings, the remainder of this sum being spent on salaries and maintenance including the medical college.

Dr. McLean dwelt upon the clinical facilities afforded by the various units of the city hospitals. About 1,000 patients on an average were hospitalized at city expense. These might be available for clinical teaching to a much greater extent than they have hitherto been used, at no increased cost to the municipality. The necessary laboratories, amphitheatres and equipment are already in existence.

The utilization of Detroit City hospital and the University hospital would not of necessity exclude the hospitals elsewhere in the state. Such details could be worked out satisfactorily. The fact that the State University possesses the personal as well as the material equipment for teaching gives it a favorable advantage. The clinical facilities of the city of Detroit and the University hospital in a sense supplement each other.

The action of the State Medical Society in endorsing graduate work in medicine

has answered any question as to the desirability of such a movement.

The physician is an individualist, and so far as Dr. McLean could see, always would be. Therefore no such movement as post graduate instruction in medicine could be construed as favoring socialized medicine.

Dr. McLean thought that broadly speaking graduate education ought recognize two classes of student, namely the man who works for credit, perhaps towards a graduate degree and he who goes in for short time work. In the former case men should be given every facility for individual work. They should be active in the work rather than passive and receptive. In fact graduate studies would be pretty much after the method which already prevails at the State University.

Dr. McLean as a member of the Detroit Board of Education assured the audience that Detroit would be willing to co-operate to the fullest extent to make graduate work in medicine a success. To improve the intellectual standing of the physician is a direct benefit to every citizen of the state.

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WALTER H. SAWYER, M. D.
Regent of the University of Michigan

Mr. Toastmaster and Friends:

We have keen joy and pride in your visit to Ann Arbor today and your interest in the things we are doing here. Your presence is evidence of the constructive work of the State Society. Looking back over an experience of more than 40 years, the progress of the society in its standing, its ideals, and its beneficience, has been tremendous. It is no longer a loose organization but an institution—an establishment. The fact that such a group is assembled here reveals the incentive which it has inspired. It is a consummation in which all can have a just satisfaction.

As you know, the society is interested in the very important matter of graduate teaching of medicine in the state, and by the university. To this end a committee was named to try and bring this about. As a result of this purpose and effort, the Regents have provided for the initiation of such a course by the following action:

"The subject of post-graduate medical courses was taken from the table. The Board approved the establishment, within the Medical School, of a Department of Post-Graduate Medicine and named Dr. James D. Bruce as the head thereof, with the provision that during the year 1927-1928 a beginning would be made toward placing the work of this department in operation. The organization of the Department of Post-Graduate Medicine is to proceed, under the charge of Dr. Bruce and under the usual conditions governing a department of the Medical School, along the lines laid down in communications from Dean Cabot."

This does not mean that the university desires to or can do all that is needed in this field. We only plan to do as best we can our part—and trust it will be a creditable part. Today we have an amount of clinical material which we did not even dream of some years ago, and which should be utilized for the benefit of the profession and of the state and country.

Detroit should do the same. You have a fine school and a distinguished group of men with a wealth of clinical material. It should be digested and used, as it is not used at present. You can and should develop your graduate teaching. There is no competition between the University Medical school and the Detroit school. We are as much interested in your growth and development as you can be. If this were not our attitude we would not be worthy of our place in the educational system of the state. Detroit is a great city and is remiss if it does not build a great teaching institution with all that modern conditions demand. Detroit will be better for it and the profession will be what only a profession can be that has the stimulus and urge of teaching.

You can count on the university doing all it can to promote such an effort. We are interested in you and what you do and want your interest in us. We can and should be harmonious and mutually beneficial. Count on our co-operation and helpfulness.

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GUY L. KIEFER, M. D.
State Commissioner of Health

The policy recently adopted by the Regents of the University to extend the scope of medical teaching so that practitioners may be able to keep up with the progress of medicine, is commended by all thinking physicians in Michigan. This post graduate instruction, if we choose to so name it, should take advantage of all the many facilities to be found in the state. All institutions from which can be taken something for the benefit of the doctors of the state in the way of medical teaching, should join in this great co-operative plan. The big city of Detroit with its wealth of clinical material and its large number of competent teachers could join in giving post graduate clinical conferences which would far out do the post-graduate conferences now given under the auspices of the State Medical Society and which are so

popular with the profession. Similar work might be added in other cities. All advances in public health work and the proper relation that should exist between public health departments and practicing physicians could be shown by the staff of the State Department of Health at its headquarters in Lansing as well as by various properly constituted, well managed and correctly equipped city health departments in various cities in the state.

The central and chief unit of such a cooperative post graduate course of instruction would properly remain at Ann Arbor and the University of Michigan with its ever increasing building program could well take care of its share of the undertaking. Such a plan, well worked out, would do more to advance the practice of medicine and relegate to the background the practice of cultism than any other that could ever be thought of, to say nothing of being developed. The results to be expected from such post graduate instruction would be a feeling of higher respect and greater confidence on the part of the public for all of the medical profession and very justly so.

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DEAN W. H. MacCRACKEN

We regret being unable to publish Dr. MacCracken's remarks for the following reason:

"Your letter of November 27, finds me ill in bed and not able to comply with your request relative to an outline of my brief talk at the dinner given at the Michigan Union on November 18.

If I may trespass on your kindness I will ask you to make whatever statement you see fit on my behalf.

Assuring you that my willingness for co-operation marches hand in hand with your own and with the kindest personal regards, I remain,

Yours sincerely,
W. H. MacCracken, M. D., Dean."

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ALEXANDER W. BLAIN, M. D.

There is little doubt in the minds of those here this evening that there is a great demand for post graduate study, not only for the man who has completed his college course and wishes more extensive training along some special branch of medicine, but also shorter courses for the man who has been out a number of years and wishes to brush up; to get the moss off his back as it were.

The great laboratories which are being developed at the university should be used further in the education of the practitioner than they are at present. In Detroit the clinical material available is enormous. It is gradually being put into better form. About 14 months ago there was established in Detroit the Detroit Post-Graduate School of Medicine, organized as a not for profit corporation under the Michigan laws. The staff is made up of some of the foremost men in connection with the various large clinics. There is no doubt that clinical medicine is best studied and best handled where the clinical material is most abundant.

There is no doubt that the medical men of the future will demand more and more post graduate work at the larger clinical centers. I am most heartily in favor of any effort to push post graduate and research work in Michigan, whether it be the long courses leading to the turning out of trained specialists or in the shorter courses for the older, busier practitioners. There is ample material in Detroit but concrete plans for its full utilization still have to be developed.

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HERBERT E. RANDALL, M. D.
President Michigan State Medical Society

The chairman tonight is my friend, your friend, our friend. Dr. Henderson has, I believe, done more for the profession of medicine than any other man outside of its membership. When he quotes the Bible and speaks of human nature, which is not taught in the medical curriculum, perhaps it might be better for medicine students to take a course in theology, rather than in the basic sciences.

The department of medicine has always been doing post-graduate work. I know of several doctors of Flint who have made frequent trips to Ann Arbor and consider it good post-graduate work. The only thing that seems to be lacking is to get organized and to hang out the welcome sign.

There is a peculiar situation developing in this country, touched upon by Dr. Bruce. In Chicago the question was asked, "What do you do when you are taken sick?" A majority of those of whom this question was asked—did not go to see a physician, they went to the drug store, to the drugless cults, osteopaths, chiropractors, and religious healers. And yet the American drug bill last year was 700,000,000 of dollars, and of course this was not all prescribed by physicians. Is medicine meeting the requirement of the people? Are we shut-

ting the front door, while the legislature is opening the back door?

The medical department exists primarily to train students to be physicians, according to its charter. Your existence is only justified when you carried this out, because neither of us believe in socialistic medicine. The aim of the medical department should be to make the under-graduate a general practitioner, also to see that our specialists are truly specialists, not self-appointed and elected. The general practitioner should be the aim of the medical department and the specialist should only be built on the good clinician. The clinician comes back to perfect himself and then calls himself an internist, while other practitioners come back to take up a specialty.

I think many of us feel that the medical course is too long. Yale has recently cut off a thousand hours, and Harvard one-third of the time. Perhaps our whole system is wrong and needs revision. The so-called logical methods leave the student with his knowledge in water-tight compartments. His knowledge is not correlated. For instance, perhaps the best time to study fractures would be while he is studying osteology.

My only personal preference is the natural or the French methods, in which the avowed purpose of medical education is to make a clinician. Under our system today, students are taught by specialists and consequently the graduate has his aim to also be a specialist, rather than a practitioner of medicine. This is the natural fruit of the system.

While Dr. Darling is to be credited with having suggested these meetings for informal discussion for medical education and co-operation between the state society and the faculty, we all recognize the generous reception given to us by the faculty and regents. Today is another day, evidencing the desire of our state university to further the interests of better medicine and of their hearty desire of co-operation.

Someone has pictured the future doctor as having a Pantechnicon waiting out in front of the house, while he goes in and asks the patient what he thinks is the trouble. A Pantechnicon is a moving van with X-ray and chemical and microscopical laboratories with assistants in each line.

Frank Billings says that the painstaking general practitioner makes an accurate diagnosis in a great majority of cases and Bevans says that 90 per cent of the paitents require no hospital treatment.

It would seem that medicine would become more simple instead of more complicated as it becomes a true science. What we really know, seems very simple, and the laboratory is only necessary in, say less than 25 per cent of the cases for diagnosis.

What I am pleading for is training of young men to use their senses to make a diagnosis rather than dependence on the laboratory.

The general practitioner, as a rule, does not do his own laboratory work. The specimen is sent to the laboratory. Medicine is still an art—cannot be taught in a medicine course.

Post-graduate work then should meet the needs of two classes of physicians. First, the man who wants to brush up. He will become the internist. And second, is to care for the general practitioner who comes back to take up a specialty.

Perhaps we are attempting too much with the undergraduate and not enough with the graduate. I suspect we are still carrying too much of the philosophy and scholastics of the middle ages down to just the beginning of the scientific age of medicine.

The regents of the University of Michigan are to be congratulated on their vision that medical science, being progressive, a medical course is never finished.

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DEAN HUGH CABOT, M. D.

It had not been my intention to discuss the subject of post-graduate teaching this evening, since it appeared to me to be in very capable hands. It will perhaps, however, be proper to review the situation briefly in its relation to the medical school.

It cannot be doubted that at this period in the development of medical practice opportunity for post-graduate study is of more importance than at any earlier time. The science of medicine is undoubtedly moving more rapidly and there are constantly being added methods of diagnosis and treatment, the precise value of which can only be determined by their wide use in the practice of medicine. It therefore follows that the contemporary practitioner will fall behind more rapidly than heretofore and that there is more need of his intimate relation to the newer possibilities than has been the case in the past. It is also true, as has been pointed out by Dr. Bruce, that the number of physicians in relation to the population has decreased importantly with the consolidation of med-

ical schools and that this decrease will continue for some time. On the other hand, I think evidence is lacking to show that the proportion of physicians to the population has in fact fallen to the point where there is any shortage or in fact, any probability of a real shortage. It does mean, however, that the physician must keep more thoroughly abreast of the times and that opportunities must, therefore, be provided to enable him to do so. With this need the university is familiar and has been at all times in complete sympathy. When the matter was first brought to our attention by the Council of the Michigan State Medical Society, it was carefully considered, forwarded to the Board of Regents with recommendations for action and that board duly set upon it the stamp of its approval. It will be obvious that the matter is so important and might readily involve the university in so much added expense that progress must take place slowly. It would be easily possible to involve the state through the university in an expensive and not wholly profitable experiment. With this in view, and yet being in entire sympathy with the program, the Board of Regents has established a department and appointed Dr. Bruce as Director of Post-Graduate Medicine. This creates the machinery necessary to organize our work here so that it may become available as soon as possible for this purpose and also to study the various other methods by which medical extension may be made most useful.

It is my own judgment that the post-graduate work of the university should not be confined to the members of the faculty here at Ann Arbor, but should call to its assistance men practicing in the other medical centers of the state and attempt to correlate the teaching which they might do with that which can be best given here. I can see no cause of complication between the interests in other medical centers and those at Ann Arbor. We are all anxious to do the same thing; namely, enlarge the opportunities for post-graduate study and make the widest possible use of teaching material. The development of a post-graduate school in Detroit would be in everybody's interest and should conflict in no way with any other development which might take place here. I am wholly in sympathy with such development; believe that the necessary machinery has been set up and that we can properly expect steady progress in this important field.

I wish particularly this evening to set before you some evidence of the working of the apprentice system which, as we announced a year ago, we are trying to work into the medical curriculum. It was suggested at that time that it would be desirable to bring students into contact with the general practice of medicine during their college course and that we hoped to do this by, so to speak, apprenticing undergraduates to general practitioners during the summer between their third and fourth years. During this last summer, we have tried such an experiment on a small scale by sending out ten students to spend a period of two months with a general practitioner who had agreed to look after him and who was, therefore, appointed by the Board of Regents as a "Preceptor of Medical Students". I have corresponded with these physicians and interviewed the students. The results appear to me wholly satisfactory. The preceptors unanimously report that the students were interested, did their work well and proved themselves helpful. The students are very enthusiastic. They all believe that their view of the field of medicine has been importantly enriched. They feel that they are bringing to the final year of their course a somewhat better understanding of the work in which they will be engaged and they all agree that it has been of great value to them.

While this is, of course, an experiment on a very small scale, it seems to me sufficiently encouraging so that we ought to extend it with a view to determining whether it will not be possible to incorporate it in the curriculum in such a way that it will give this opportunity to all students. It is, therefore, our intention to extend the work during the coming summer. It will go without saying that the success of this will depend entirely upon the cordial support of the profession. Without this it cannot go far: with it, I have little doubt of its success. It appears to me one of the best methods of keeping the profession in touch with medical education and thereby enabling us to take advantage of suggestions for improvement of the course based upon intimate personal contact with the students. I appeal, therefore, to you gentlemen to assist us in this work.

Some reference has been made this evening to the length of the medical curriculum and its apparent tendency to grow longer. This has been regarded in some quarters as seriously objectionable in that it brought the student to his active work

later in life than was desirable. Of the soundness of this conclusion I am somewhat doubtful. It seems to me that the public is taking a very different view of the young practitioner from that which it entertained a generation ago. All of us can remember the lean years of early practice while we waited for older men to die and until our appearance lost its youthful character and we were regarded as sufficiently mature to assume the responsibility. Today the public is much more prepared to accept the advice of younger men and I think this attitude is based upon the belief that they are in fact better trained than was the case in our day. The younger practitioner is now much more nearly on a par with his senior colleague and can expect to step rapidly into active practice without the earlier period of waiting. From this it appears to me to follow that some additional maturity is not only desirable but essential. If the public has come to regard him as a satisfactory counselor, he must in fact be better equipped to play the part and the mere time element now expended on his education appears to me to be an advantage rather than a detriment. Not so long ago the average practitioner of medicine was in fact a better educated man than almost any of the other members of his community with the exception of the minister and perhaps the lawyer. Today education is much more widely spread. The physician is not in fact better educated and does not, therefore, take high position in the community through the mere fact of his education. A broad and reasonably long period of study is needed if he is to be equipped to hold his own in a community which will expect of him not only a knowledge of the science and the art of medicine, but also sound judgment upon the many economic and social problems of the day which are inseparably bound up with the ills of mankind. We do not want, and we should not tolerate, any tendency on the part of the medical profession to fall back from the high estate which it has always occupied. If such a decline is to be avoided it can be most surely prevented by seeing to it that the breadth and depth of the education in medicine keeps pace at least with the advancing level of education in general.

## PRESIDENT COOLIDGE ON FEDERAL AID TO STATES

A few years ago President Coolidge expressed himself as definitely opposed to that plan whereby the federal government allocates certain sums to the states which are willing to allocate similar sums for special purposes. In his budget message submitted to Congress, December 7, the President again announced his views on this point. He pointed out that the authorization for the promotion of the welfare and hygiene of maternity and infancy expires in 1929, and that the last extension of the act was approved with the understanding that its administration during the two added years would be with a view to the discontinuance of federal aid thereafter. That he considered the dangers inherent in the policy of federal subsidies to the states of far greater importance than any financial burden that might be incurred is shown in the following statement:

> To relieve the states of their just obligations by resort to the federal treasury in the final result is hurtful rather than helpful to the state and unfair to the payers of national taxes. To exempt the states by federal subsidies to sacrifice their vested rights is not a wholesome practice no matter how worthy the object to be attained.
>
> Federal interference in state functions can never be justified as a permanent continuing policy, even if, which is doubtful, such interference is warranted by emergent conditions as a temporary expedient. As shown in the maternity and infancy act, when once the government engages in such an enterprise it is almost impossible to terminate its connection therewith. We should not only decidedly refuse to countenance additional federal participation in state-aid projects, but should make careful study of all our activities of that character with a view to curtailing them.

It will be interesting to observe whether the too enthusiastic proponents of this legislation will endeavor again to urge its passage, regardless of the President's views and of their tacit understanding with the federal government.—*Jour. A. M. A.*, Dec. 24, 1927.

## COUNTY HEALTH WORK

Charles H. Laughinghouse, Raleigh, N. C. (*Journal A. M. A.*, Dec. 24, 1927), suggests that medical education should devise ways and means to prepare physicians in the future to practice the specialty of public health more capably. The office nurse for the rural physician should be popularized. Boards of health could add nothing to their present plan of prevention of disease which would show more immediate and more satisfactory results than the institution of training schools for nurses whose specialty would be to give assistance to the physicians in rural districts who are practicing general medicine. Extension courses by medical colleges for the purpose of bringing special training to the very doors of the rural physicians themselves in isolated communities would prove of untold benefit in the development of county health work. Lectures and clinics by itinerant teachers in the small towns and country communities to which the local profession could be invited and in which the early diagnosis and prevention of disease could be taught and stressed would mean much to the furtherance of county health work and to the attractiveness and safety of rural life.

# EDITORIAL DEPARTMENT

EDITOR: Frederick C. Warnshuis, M. D., F. A. C. S.

ADDRESS ALL COMMUNICATIONS TO THE EDITOR—1508 G. R. NAT'L BANK BLDG., GRAND RAPIDS, MICH.

## ANNUAL MEETING OF THE COUNCIL

The annual meeting of the Council of the Michigan State Medical Society will be held in Detroit, at the Book-Cadillac hotel, on January 11th, 1928, at 9:00 a. m., fast time. The regular order of business will consist of all matters pertaining to the affairs of our Society.

R. C. Stone, Chairman.
Attest: F. C. Warnshuis, Secretary.

## SURVEYS OF SURVEYS

The Bureau of Public Health and Instruction of the A. M. A. has conducted a partial study of the number and scope of surveys that deal with public health and which have or are being conducted. The study covers a period of some twenty years and uncovers some interesting facts. Practically every phase of public health has been touched and every state in the union has been a field of work. There have been some 982 separate investigations, and the United States Public Health service is credited with 1,013 surveys.

In Michigan we have had 32 surveys classified as: Cities 7, General 2, Maternity and Infant 2, Venereal 14, Tuberculosis 1, Sanitation 1, Health Education 3, and Miscellaneous 2.

As one surveys these surveys many questions arise: What was accomplished? What were the conclusions? What was the need? Were the findings followed up and corrective measures instituted? Was there a subsequent check-up?

Then, too, was there not destructive confusion and reduplications? Could not these facts be obtained just as adequately with less cost and labor in the decenial census? We are of the opinion that the majority of these surveys serve but one main purpose and that is to give employment to a horde of so-styled directors, supervisors, field agents, canvassers and secretaries at given salaries and expenses.

The preliminary facts seem to warrant the conclusion that the utter uselessness of a majority of surveys should be widely disseminated for the public's information. Also, that the money expended for these surveys might well be appropriated to more worth-while objects. There are far too many incompetent, social economists preying upon the public in their useless endeavors and far too insufficient worthwhile, constructive work.

## FLINT ORTHOPEDIC SCHOOL

Three years ago a small class was organized and a teacher was employed by the Board of Education for the education of Flint's crippled children. That group has gradually increased. Last year there were 40 children enrolled and another teacher was added. This year Flint has an Orthopedic school with an enrollment of 80 children and a staff of three teachers, an occupational therapist, a physiotherapist, a matron and an attendant. Another teacher will be employed the second semester this year. Space and equipment are being provided as the needs arise.

The Rotary club of Flint, employs the services of a graduate nurse who spends several hours daily at the Orthopedic school assisting with physiotherapy and inspecting the corrective equipment worn by the children.

The children are transported to and from school in taxicabs. They are given milk and a warm lunch prepared by the matron at noon. They are taught various kinds of occupational handwork as well as the regular academic work. They receive massage and muscle training according to their conditions.

All expense for this Orthopedic school is cared for by the Flint Board of Education.

Every child in the school has been examined in the school orthopedic clinic which is held once a week for the benefit of Flint's crippled children.

More than 50% of the children in the Orthopedic school have had infantile paralysis, about 10% are spastic paraplegia and 40% have osteomyelitis. A few have congenial deformities and a few are crippled because of accidents.

All of the children of the Orthopedic school are under medical care.

G. J. Curry.

# SCIENTIFIC PROGRESS LAST YEAR

Scientific progress is recorded with each passing year. The tenets of yesterday are discarded as new, proven knowledge refutes their tenability. New principles, new facts beget new methods and more efficacious therapy. All these advances demand an ever constant alertness lest one drops to the rear of professional capability. To remain abreast, to apply in our daily work modern methods and practices requires constant, sustained reading, study and attendance at medical meetings. In no other way can one keep pace with the advance.

It is to that end, to aid our members, that we requested certain of our members to prepare for The Journal, a brief citation of the progress that was recorded last year in the several main branches of medicine. They have complied with our request and their comments are herewith submitted for our members' information.

## PROGRESS IN CARDIOLOGY FOR THE YEAR 1927

M. A. Mortensen, M. D.

It is impossible to consider all the literature that has been published on this most important subject. The abundance of literature shows the keen interest the medical profession is taking in the cardiovascular problem which is perhaps one of the most important from the standpoint of morbidity and mortality at the present time. Some new work has been offered and much important follow-up work has been done and I will attempt to refer to it in the following groups:

Physiology: Yandell Henderson and associates offer additional reports on the study of cardiac efficiency by the ethyl iodide method presented by them two years ago. They consider that cardiac efficiency is based on the volume of the blood pumped by the heart in relation to the oxygen requirements of the body. Their recent studies confirm the conclusion of their earlier investigation and as new work they offer definite evidence that the use of tobacco materially decreases the efficiency of the heart.[1]

The use of the electrocardiograph is evidently becoming more widespread and the continued study of tracings help the physician to a better understanding of the physiologic and pathologic changes in the heart. Interpretations of tracings often confirm or throw doubt on our clinical opinions and thus assist in estimating myocardial reserve.[2] The use of these methods we believe will continue to increase our capacity of determining myocardial efficiency which is of fundamental importance in cardiology.

Endocarditis. Small[3] of Philadelphia announces the discovery of specific organism of rheumatic fever, the streptococcus cardioarthridis, which, as is inferred by the name, should be of utmost importance in rheumatic heart disease. Confirmation of the preliminary announcement is looked forward to with unusual interest.

Many articles have been offered on subacute bacterial endocarditis, but nothing new presented of therapeutic value.[4]

Myocardial Disease. Janney Smith[5] reports interesting work on the effect of deep X-ray therapy on the heart muscles. Electrocardiograps tracings suggest definite deteriorating effect on the heart which is supported by pathologic evidence. If further study confirms these findings it should be of great importance in the treatment of malignancy and other conditions in the chest or mediastinum requiring deep therapy. Definite effort to protect the heart from the rays will be necessary.

Much interest is manifest in Angina Pectoris and coronary thrombosis. The trend of opinion concerning cause of pain in Angina Pectoris leads toward myocardial theory with ischemia and coronary sclerosis as the fundamental factor.[6]

Herrick reports interesting observations on the combination of Angina Pectoris and severe anemia. This supplements earlier studies on severe pernicious anemia and secondary anemia with typical angina syndrome. This combination tends to favor the coronary and myocardial ischemic therapy as opposed to the aortic theory.[7] Coronary thrombosis with occlusion is being more and more crystalized into a well understood disease entity and more frequently recognized than ever before. Differentiation between Angina Pectoris and coronary thrombosis has been clearly defined by various authors. Angina Pectoris symptoms are recognized as a result of effort, emotional disturbances with evidence of more or less myocardial inefficiency and relieved by rest and nitroglycerine. Coronary thrombosis is recognized by similar pain, both as to location and character, but not relieved by rest and often lasting hours and even days and often not relieved by the ordinary dose of morphine. Pulse rate is increased and often irregular and blood pressure is apt to be found decreased. In

a few hours pericardial friction rub may be detected in the third and fourth interspace near the sternum, slight rise of temperature and a moderate leucocytosis and congestion of the lungs, depending on the extent of the myocardial injury. This group of symptoms justifies the diagnosis of thrombosis. Electrocardiograph tracings in coronary thrombosis frequently show bundle branch block which is of diagnostic and prognostic value.[8]

Gallop rhythm[9] is emphasized as a bad prognostic omen and as warning for more careful management. Pulsus alternans is the irregularity most frequently associated with gallop rhythm and should be considered as the two most positive signs of failing heart. Prognosis is especially bad when accompanied by hypertension.

Therapeutics: Continued interest in the use of quinidin sulphate has increased its scope of cardiac therapy. Among other things it diminishes conductivity of the heart muscle and conduction system itself and represses the recovery after contraction, thus lessening the refractory period. These qualities are of the greatest therapeutic importance.[10] The drug is of recognized value in certain cases of auricular fibrillation both of the persistent and transient type, premature beats, paroxysmal tachycardia and simple tachycardia.

Salyrgan is a new diuretic recommended for intravenous use in anasarca of cardiac origin. It is contraindicated in cases of nephritis.

Brown and Coffey of San Francisco continue research work and surgery for relief of Angina Pectoris. In practically all their later cases they have limited their surgery to "removal of the left superior cardiac nerve of vagus being cut and a section taken out if possible. The latter is done to insure against any of the collaterals of the vagus having been left.[11] Their results have been satisfactory, but they have used careful discrimination in selection of cases. In most cases the sympathectomy is performed under local anesthesia. Their selection of cases and careful surgical technique is no doubt a big factor in obtaining such good results.

The results of periarterial sympathectomy suggest that its value is rather limited.

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## GASTRO-ENTEROLOGY

Elmer L. Eggleston

While the year of 1927 has witnessed no epoch-making discoveries relative to the function or pathology of the gastro-intestinal tract, nevertheless, the advancement noted in the diagnosis and treatment of such disorders has kept pace with the progress of general medicine. Standardization of diagnostic methods in use in hospitals, with an improvement in their equipment, has been fostered by the American Medical Association, also by the College of Surgeons. This has meant much to the profession in permitting men in the smaller cities to have the same opportunities as men in the larger centers. It is a work which should be carried on with the hearty co-operation of those interested locally.

The diagnosis of gastro-intestinal disorders has reached a high state of efficiency. The use of the esophagoscope both in diagnosis and treatment has meant much in the diagnosis and treatment of disorders of the esophagus. The work of the radiologist is becoming so imperative that practically all hospitals have installed excellent equipment along this line, and the training of technicians has gone ahead very rapidly. The value of this procedure is so great that a proper study of a gastro-intestinal case has not been made where this has been omitted.

Along the lines of treatment of gastro-duodenal disturbances, a more rational view has been taken by both surgeon and internist. They are no longer each one working along his own line, but are co-operating much to the advantage of the patient and to the credit of the profession. The latest surgical expression (Balfour: Minnesota Medicine, November, 1927), relative to gastro-intestinal conditions demanding surgery is as follows:

"The more experience acquired in the surgical treatment of lesions of the stomach, the greater the conviction that progress in the management of peptic ulcer will depend on a more intelligent selection of cases for operation and a better appreciation of the general principles of those operations which experience has shown to be worthy of application. I believe that most of the failures of surgical measures to cure peptic ulcer permanently can be attributed to failure in one or both of these respects."

And moreover, more care in the selection of surgical methods is constantly being urged. The same author continues:

"In both malignant and benign lesions of the stomach and duodenum it is a mistake to imply that any single type of operation will always deal adequately with the lesion."

The selection of the operative procedure of gastro-enterostomy for the relief of an unstenosed duodenal ulcer is not now the operation of choice. If done, it must be combined with a resection of the ulcer or a duodenectomy or a plastic operation on the duodenum, but more and more both surgeon and internist recognize the unstenosed cases as being definite problems for the internist and excellent results from this type of treatment are being reported.

More radical surgical measures, such as gastrectomy in the treatment of duodenal ulcer, have not met with the approval of the profession generally. Since the operation is followed by a complete achylia which is the desire of those championing the procedure, and since it is found that an achlorhydria is very apt to be followed by anemia or by a diarrhea due to colitis incident to the achlorhydria, a strong opposition has developed and it is quite probable that the procedure will not become at all popular.

In the medical treatment of peptic ulcer, certain modifications of the Sippy method are being advocated. The alkalis are not found to be of value in the amounts originally advised by the author of the method. Hypersecretion, symptoms of alkalosis, and renal disturbances, are being reported more frequently where such treatment is in vogue, whereas a reduction of the alkali to one-fourth or one-eighth accomplishes all that is apparently necessary in the way of neutralization, and under this regime the patient promptly loses the symptoms of toxemia due to the excess of alkalis.

The regulation of gastric acidity by means of regurgitation of the duodenal contents has received further study and under normal conditions, in the absence of pyloric stenosis, there is no doubt but that an optimum gastric acidity is produced which lessens the necessity for the use of alkalis except in very small quantities.

The pathology of the duodenum other than ulcer has received considerable study, especially duodenitis due to infections that are probably blood borne. The supposition is that this may be a factor in the formation of duodenal ulcer or duodenal illeus. The latter, when due to obstructive lesions, malignancy, or pressure from growths outside the duodenum, or adhesions, or to mesenteric drag, as in cases of visceroptosis, respond well to operative treatment, duodeno-jejunostomy being the operation of choice. The cases more functional in character do not respond well to surgery and are medical problems. In the visceroptotic type the value of physical and postural treatment is evident.

Along diagnostic lines of liver and gallbladder disorders, the functional tests are still attracting much attention, not that any test so far suggested gives an estimate of the complete function of the liver, but it is probably an indication of some specific function and is very definitely of value. Cholecystography is of great value in determining gallbladder dysfunction and pathology and is the most valuable diagnostic procedure perfected in recent years. There is still some question as to the administration of the dye, as to whether it should be intravenous or oral. Certainly the results are more dependable following the intravenous method, but the procedure may require more skill and equipment than is furnished by the small hospital.

Along the lines of intestinal diagnosis and therapy there has been definite advancement. There has been previously a notable lack of information relative to the intestinal tract which is being corrected by more careful histories, of the almost routine use of X-ray, and careful rectal and lower colon examinations by means of the sigmoidoscope. Along this line it might be mentioned that the work of Bargen, Logan and Buie still stands out as being exceptional in the diagnosis of ulcerative colitis. The so-called nonspecific type of ulcerative colitis they believe to be due to a diplococcus and their treatment is largely the use of a vaccine or filtrate. The frequency in which they make this diagnosis and the remarkable results which they report are exciting considerable interest, and while the profession has not entirely accepted their views, their statements appear very convincing. More rational treatment of rectal disturbances, ulcers, fissures, hemorrhoids, cryptitis, etc., have been provided by the proctologists and they have done much toward relieving one cause of chronic intestinal stasis. There has been a still greater departure from the use of cathartics in intestinal stasis and such simple measures as regulation of diet, the use of mineral oil, a bulky diet as provided by bran and green vegetables and the use of such measures

as kaolin and psyllium seed, has accomplished much in the relief of this unsatisfactory condition.

## NEUROLOGY

C. D. Camp, M. D.

The year 1927 has seen no outstanding publications in the field of neurology. However, one makes this statement with considerable reserve. It is entirely possible that in some medical journal or book an account of experiences and observations have been published that future generations will herald as a great discovery. The original publications of Mendel and Freud for instance, attracted no attention at the time. Those who think that they have published important discoveries should not be discouraged through lack of immediate appreciation.

In psychology the year has been chiefly notable through the number of papers and books dealing with "Behaviorism" and "Individual Psychology". There seems to be a tendency to neglect the older tenets of psychology founded on philosophic principles and to accept the more objective study. Even psycho-analysis has been pushed into the background.

In neurological anatomy the most important works have dealt with the anatomy of the basal ganglia and mid brain for instance, the paper by Freeman on the arrangement of the primary afferant centers in the brain stem (Jour. of Nervous and Mental Diseases, January), another by L. O. Morgan (Arch. of Neur. and Psych.), and the book by Foix and Nicolesco on the mesencephalon and sub-thelamic region. The anatomy of this region is extremely intricate and something still remains to be done. In the physiologic field also the main focus of interest has been on the brain stem, the paper by F. T. Rogers in the American Journal of Physiology being perhaps the most notable contribution.

In the field of neuropathology and clinical neurology a great deal of attention has been devoted to encephalitis, especially the chronic form characterized by the Parkinson syndrome or by various types of mental disturbances, anomalies in breathing, et cetera. The etiology of epidemic encephalitis cannot be considered as settled. Hand and Reilly published a rather interesting suggestion that Raynaud's disease in children might be due to hereditary lues. In these cases the diagnosis of lues was not apparent in the patient, but was made by blood examinations in the parents. Munck (Jr. of Nervous and Mental Diseases) on the basis of a number of medico-legal examinations, showed that spontaneous subarachnoid hemorrhage might cause sudden death. There have been a considerable number of publications on multiple sclerosis without, however, adding very much to our knowledge either of the etiology or symptomatology of this important disease. Kolb has published his views concerning drug addiction on the basis of the study of several thousand cases. He believes that true drug addiction always occurs in patients who have a pathologic nervous constitution. People who are perfectly normal run little danger of becoming addicts. It is an interesting observation that drug addiction may be periodic, similar to periodic drinking. The articles by Lapinski (Arch. f. Psych. 82, 43), on the mechanism and location of reflex pain arising from the viscera are of interest not only to the neurologist, but also to the surgeon.

Along the lines of thearpeutics the chief developments seem to be in the use of serums and in endocrine therapy, but the published reports of cures are not altogether convincing. In the Journal of Nervous and Mental Diseases, February, Freeman publishes an article, the vaccine treatment for encephalitis, but with an absence of control cases. The use of serums for anterior poliomyelitis has also attracted considerable attention, but they can hardly be said to rest upon a scientific basis at the present time. Perhaps the best suggestion that is made in this connection is the use of sera obtained from a recently cured case of poliomyelitis. In the treatment of migraine Tigges (Deut. med Wochenschr.), advises nasal application of cocain and adrenalin. Bigland (British Medical Journal) has tried giving calcium lactate in thirty grain doses, but the results were not encouraging. Hahn and Stein (Zeit. f. Nervenheilk.) suggests the use of intravenous injection of papaverin at the onset of an attack. The malaria treatment of paresis continues to attract considerable attention. A good review of the subject by Ferarro and Fong is found in the Journal of Nervous and Mental Diseases. Some modification of this method has also been tried as for instance, the substitution of an infection by sodoku. Most of the reports have been rather enthusiastic regarding their results, but it is obvious that a considerable period of time must elapse before anyone can say that a cure has been obtained.

Attention might be called to the death of Bianchi, the celebrated Italian neuro-

pathologist, who died in Naples; also the death of Foix of Paris. In America we regret the death of Dr. T. W. Salmon of New York and of Dr. S. G. Webber, who was one of the founders of the American Neurological Association.

## COMMENTS ON THE PROGRESS OF DERMATOLOGY IN 1927

R. A. C. Wollenberg, M. D.

Contributions in this branch of medicine have been many and interesting, and the fact that new names are regularly appearing as authors in a field in which important clinical, pathological, and therapeutic knowledge is rapidly growing, attests the interest that our younger and enthusiastic colleagues find in this specialty. There are none to deny that Ehrlich's great discovery re-awakened an interest in syphilis in particular and in dermatology as a whole which has not yet been spent, but, on the contrary, is still drawing many of the keenest medical minds into the pathways he blazed.

The one great result achieved by intravenous medication has been the elimination of self-drugging by sufferers from syphilis, and never before have these patients been under such medical control as they are today. In consequence, the cure of syphilis is still an outstanding challenge to the medical profession. Certainly, the cure of our patients is not the least of our functions.

The controversy as to the relative merits of arsphenamine and neoarsphenamine still continues. Safety and simplicity of administration are, no doubt, the great advantages of the latter, although its therapeutic efficiency, dose for dose, is less. Notwithstanding, serious symptoms still occasionally follow its use, and a number of diluents other than water have been used in order to avoid such annoying and disappointing phenomena. Of these, glucose gives the most promise.

Of the newer arsenicals, stovarsol, called to our attention by French investigators, has the advantage that it can be given by mouth. Clinical studies in this country prove it to be useful in controlling the clinical manifestations of syphilis and to show a serological improvement. It may become very useful as a prophylactic. It is a pentavalent arsenic, containing 27.2 per cent of the metal, higher than neoarshphenamine. Its efficacy is comparable to the latter, and its tolerance is higher.

Fortunately, deaths from use of arsenicals are more rare, but a recent one from purpura hemorrhagica following sulpharsphenamine was found in the literature.

In this connection, it may be well to mention that this year has produced further facts to substantiate the value of sodium thiosulphate in arsenic poisoning, especially when administered early. Treatment with arsenic should be suspended and sodium thiosulphate should be administered intravenously at the first sign of the eruption. By mouth, it acts as a violent purgative, and large doses are not tolerated.

Bismuth has only recently been added to the antiluetic group of drugs, and, as an insoluble compound suspended in oil, has come to be popularly used as an intramuscular injection. It is absorbed very slowly, may be indefinitely deposited, and, with our increasing knowledge of oil tumors, regarded as precancerous, it may be well to speculate on the remote results of the countless number of such treatments being given today. Oil tumors may not appear until many years after injection, and they have been shown to be even permanently disabling. Whether or not the indiscriminate use of the insolubles is inviting a dangerous reaction, or whether, in the words of a prominent dermatologist, "the needle may be more dangerous than the disease", only the future will disclose. However, the value of bismuth in syphilis is undisputed, and, with the purpose of providing a compound which can be injected intramuscularly without causing injury to the tissues and which will not form a deposit at the site of injection, a soluble bismuth compound of thioglycollic acid has been prepared and studied in experimental and clinical syphilis. It apparently produces more rapid improvement in lesions than the insoluble bismuth compounds.

Attention is drawn again to the possible danger of bismuth poisoning. It is eliminated in the urine, feces, bile, and saliva. If elimination be prevented or absorption be too rapid, intoxication may occur with symptoms of stomatitis, gastro-enteritis, circulatory disturbances, fever, nephritis, and changes in the central nervous system.

Reports on the malaria treatment of central nervous system syphilis show results which warrant the use of this therapy in cases which show no further betterment by the other recognized methods. In Europe, especially, malaria treatment is now well established.

In the serology of syphilis, the Kahn precipitation test has now become the official test in several state laboratories. Elsewhere it remains an excellent check on the Wassermann reaction, and, to obtain

the greatest possible accuracy, it is best to employ both.

Great advance has been made in the treatment of that persistent and intractable disease, lupus erythematosus. Gold and sodium thiosulphate has been used with results so striking that it appears to have almost a specific effect. In a large number of patients treated during the last year, the majority have improved and many appear cured. Also, some cases of lupus vulgaris have shown improvement.

In the treatment of local and general infections and other diseases mercurochrome —220 continues to hold attention in the dermatological field. Its intravenous use has met with success in the following diseases reported: anthrax, cellulitis, erysipelas, resistant furunculosis and carbuncolosis, madura foot, and some cases of psoriasis. Locally applied, quick and excellent results have been obtained by a 2 per cent solution of gentian violet in impetigo contagiosa and other superficial pus infections.

The literature on fungus diseases of the skin reveals the increasing importance of this subject. Unfortunately, there is a great confusion of names for the many species of fungi affecting the skin, and whether certain moulds are to be called epidermophytons or trichophytons, is not yet settled. Noteworthy laboratory studies on the fungi have been made in this country. A new type of mouth infection by the monilia pinoyi, a yeast, has been reported. It is closely related to thrush. There were also reported two new species of mould in maduromycosis. Infection by fungi appears to be very common throughout the world, many cases are very resistant to treatment, and there is marked tendency to recurrence. The dyes, salicylic acid, mercury, and X-ray in the hairy parts remain our chief therapeutic armament.

That such hackneyed subjects as smallpox and vaccination should continue to engage the attention of writers should surprise no one. Our recent experience with outbreaks of malignant variola in various states suggests one to paraphrase the old maxim, "Eternal vigilance is the price of liberty" to "Infernal pestilence is the price of negligence."

It is stated that the Minnesota law requiring vaccinations was repealed in 1903 with the result that a large part of the population is now unprotected against smallpox. From 1913 to 1923, this state had over 35,000 cases with 108 deaths. Of these cases 94.1 per cent had never been vaccinated. Of those vaccinated over seven years before, there were 4.2 per cent. Of those vaccinated within seven years, there were 1.7 per cent. In this group none died. The lesson is obvious to any one with an open mind. Smallpox, a loathsome pest, can be stamped out by vaccinating every seven years, and there is no better treatment than prevention.

The year 1927 marks the passing of Dr. Milton Bixler Hartzell, a master dermatologist, a student of Louis A. Duhring, whom he followed as Professor of Dermatology at the University of Pennsylvania. Dermatology has recently sustained further great loss in the death of Dr. T. Casper Gilchrist, for many years associated with Johns Hopkins university.

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## NOTES ON THE PROGRESS OF ROENTGENOLOGY AND RADIATION THERAPY DURING THE YEAR 1927

Preston M. Hickey, A. B., M. D.

The teaching methods of roentgology to under-graduate students have shown notable progress. A number of anatomic laboratories have installed X-ray machines for the use of students in studying anatomic material. The film and fluoroscope are systematically employed in giving the medical student a different viewpoint in the study of anatomic structure and also in demonstrating the function of various organs. The use of the projection apparatus by which X-ray films can be directly thrown upon the screen permits of the demonstration of these films in all their original detail to large groups of students.

The use of the tetraiode of phenolphthalein in the study of the physiology of the gall-bladder and in the demonstration of its disturbed function has increased in popularity. There has been a growing tendency to the employment of tetraiode by the oral method in routine cases, reserving the intravenous introduction of the dye for an increasingly small number of selected cases. There is a tendency to substitute for the capsules of the dye a palatable solution which can be administered in one dose which marks a further step in the popularization of this useful method of diagnosis.

The use of iodized oil during the last year has also come into more general use. The technic for the introduction of the oil into the lower air passages has been simplified and the positive demonstration of bronchiectasis and lung abscesses is permitting of a more positive diagnosis of these pathologic processes. In the upper air passages the filling of the para-nasal sinuses with the iodized oil is opening up an additional means of study of their

anatomy and pathology. The non-filling of the sinuses because of pathologic exudate or swollen ostia, or the prolonged retention of the oil after introduction constitute the basis for conclusions as to the presence of pathology. The work in this field is arousing considerable interest and the indications are that it will be a very promising field for future research.

The use of iodized oil in the demonstration of pathology of the uterus and the uteri adnexa is attracting the attention of many clinicians and it bids fair to assume a prominent place in the diagnosis of strictures and patency of the Fallopian tubes. Several articles, however, have appeared showing the dangers of its indeterminate use and showing the necessity of a careful selection of cases where it is to be employed. The contra indications are against its use in tubes which have an active or latent infection. The use of the iodized oil in the diagnosis of early pregnancy has been shown to be attended with the danger of producing abortion. Some of the previous writers on this subject had claimed that the introduction of the iodized oil into the uterine cavity in early pregnancy was not attended with the possibility of producing abortion. From the experience of more extended observation it has been found that the danger of abortion in these cases is about 20 per cent, a proportion which would prohibit its routine employment.

A very notable improvement during the past year in the X-ray diagnosis of pulmonary conditions has been made possible by the work at the Phipps Institute in Philadelphia. Dr. McPhedran of that institute has demonstrated that it is possible to obtain exposures of the lung fields with very short exposures made during the same phase of the cardiac cycle. This has made it possible to demonstrate certainty by removing the haziness of films of this area due to the blurring from the cardiac impact. The diagnosis of pulmonary tuberculosis in children which has always been a most difficult matter seems now to be making headway with promise of an ultimate solution.

The experiments with the new cathode tube are being actively conducted, one of the results which bids fair to be of practical importance is the discovery that in certain foods the vitamin contents can be strikingly increased. Many of the observations of the change in the physical attributes of certain chemical compounds under the action of the cathode stream lead one to prophesy that the new tube will be extensively employed in experimental chemistry. It is noteworthy that Dr. Cooldige has been able to increase the voltage from the 200,000 volts which he employed in his early type of tube to 750,000 volts, increasing the possibility of greater chemical changes.

The Bureau of Standards at Washington has installed a department for the study of the problem of standardization of protective materials such as lead glass, opaque gloves and aprons used in Roentgenologic laboratory. The Bureau of Standards is also occupying itself with the study of the standardization of the output of X-Ray machines. Possibly the most important advance in Roentgen Therapy during the past year has been the demonstration of the close similarity of the different units employed in Germany and America. Previous to these recent observations it has been thought that the standard unit employed in Germany varied from the standard unit employed in America, first introduced by Dr. Duane of Harvard university. Now that these two units have proven to be without practical difference, it will probably result that the next International Congress, meeting in July 1928 in Stockholm, Sweden will adopt an International Unit. If this unit is adopted, as now seems probably, it will do much to standardize the Therapy dose in all parts of the world and will allow a more exact comparison of different methods of Radiation treatment.

The so-called saturation method has been carefully studied both experimentally and clinically and is apparently gaining in popularity.

While the year 1927 has not been productive of any startling discoveries in Radiation, still there has been a gradual accumulation of authoritative studies along certain lines which is tending to place Therapy on a much sounder basis.

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## PROGRESS IN RADIOLOGY

J. H. Dempster, M. D., Detroit

Radiology or the X-ray in its broadest aspect is still a very young specialty born as it was 32 years ago. The progress of the science has been along two somewhat varying directions, namely mechanical and clinical. To mention the high spots of mechanical development, we have the discovery of the X-rays in the fall of 1895 and the discovery of their fluorescent effect on cardboard surface coated over with platinum-barium-cyanide salt. Then came the interrupterless transformer. This was followed in 1914 by one of the greatest in-

ventions of the century so far, namely the hot cathode X-ray tube known as the Coolidge tube, by W. D. Coolidge. It supplanted the original gas tubes. Since this time we have had some modifications and refinements of this tube. Later came the Potter modification of the Bucky diaphragm which eliminated in a large measure the scattered radiation, the bane of the Radiologist especially in making examinations of the thicker portions of the body. A marked advance in development technique followed the discarding of glass plates and the introduction of the duplitized film. This coupled with double screen technique, added greatly to the speed with which exposures could be made which was so necessary to satisfactory diagnostic plates of mobile parts such as the thoracic and abdominal viscera. Mention must also be made of the higher voltage machines in treatment with concomitant development of protective measures. X-ray apparatus is still very bulky, demanding considerable floor space. This is true of all but portable and dental units. The refinements in apparatus have been largely the work of the manufacturer and engineer, the Potter-Bucky diaphragm excepted.

The contribution of the clinician has been equally important in the development of Radiology. Cannon very soon after the discovery of the X-rays saw the advantage of the opaque Bismuth salts in studying the hollow viscera. The results of his studies are embodied in his well known book, The Mechanical Factors of Digestion. Soon after this Hemmeter employed the same method, namely the opaque insoluble salt of Barium, which has revolutionized abdominal diagnosis. Then came pneumoperitoneum, a method which by the inflation of the peritoneum by means of oxygen, examination of the solid abdominal and peloic viscera was facilitated. This later method as a routine has largely fallen into disuse. Modification of it however, has been employed in the X-ray diagnosis of brain tumor. A portion of the cerebrospinal fluid is drawn off and replaced by the injection of sterile air. By this method we are to obtain radiographs or ventriculograms of the lobes of the brain. Air or suitable gas in proximity to the various viscera has the effect of bringing the parts into relief. This principle has made the radiographic examination of the heart and lungs one of the most successful fields for X-ray study.

In 1923, Graham of St. Louis devised a method for the visualization of the gallbladder which up to that time had proved the most unsatisfactory portion of the alimentary tract to yield to radiographic study. Rehfuss declares the Graham test to be without question one of the greatest discoveries of this contemporaneous era of medicine. As a method for the study of gallbladder function it has come to stay. Early in the use of the method patients were found to suffer from toxic symptoms incident to the administration of the dye. This lead to further experiment and study, partly the work of the year 1927, and the conclusion has been reached that the ordinary human dose of sodium tetraiodophthalein as used in the Graham test is well under the toxic limit. Particularly is this true if administered by the oral method.

The past year has seen the development of a diagnostic method, particularly for intra-uterine conditions, by means of lipiodol. This substance injected into the cavity of the uterus and tubes is opaque to the X-rays. Radiographic examination of the injected uterus often enables one to diagnose intra-uterine or submucous fibroids or other gross pathology, or the patency of the tubes.

For some time past lipiodol has been used as contrast medium in connection with the bronchial tubes as well as the accessory or other sinuses.

Radiologists are constantly active in the devising of diagnostic methods and technique and each year sees improvements that are at least important to those who confine their attention to this field.

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## FRACTURES

A. D. Laferte, M. D.

The year of 1927 has brought marked innovations in the treatment of fractures. There has however, been some convincing evidence that various of the present methods might be used less often and then by those peculiarly apt in their use and in institutions specially equipped.

The Committee on Fractures of the American College of Surgeons has done valuable work in investigating methods and results, and in some cases of outlining principles of treatment.

In fracture of the clavicle it is almost never necessary to operate. A very efficient device is the "T" splint which when properly applied elevates, and pulls the shoulder back, immobilizing the fragments and permitting the patient to be about.

In facture of the humerus no one splint can be used in all cases, however, either the hinged Thomas or the Jones Humerus

Traction splints will care for most fractures of this bone above the condyles. The method of application of the Thomas splint depending upon the location of the fracture and the amount of rotation of the fragments. In fractures at the elbow joint, with exception of the elocranar, the position in acute flexion is standard.

There have been many unsatisfactory results in Colles' fractures. In many instances this has been shown to be due to insufficient pronation of the distal fragment in reduction, and to failure to approximate the lower end of the ulna to the radial fragments in splinting.

Most fractures of the radius and ulna can be handled without operation. The exception being that of both bones of the forearm low down within the pronator quadratus muscle. These latter are often impossible of closed reduction and can generally be held by merely opening the forearm and approximately the fragments without any internal fixation material.

Fractures of the neck of the femur may be well treated by the Whitman method. The writer prefers to impact this fracture as practiced by Cotton and treat it in the Whitman position. The greatest error in handling these cases is in allowing too early weight bearing. Fractures of the inner half the neck should bear no weight for nine months while those of the outer half should bear no weight for six months.

Most fractures of the tibia and fibula can be treated without operation. The exception being those of both bones in the lower third when the fracture of the tibia is oblique. The sliding bone graft is here the method of choice.

Various means have been tried in treating fractures of the os-calcis, the closed method prevailing. However, when the fracture extends into the sub-astragalar joint a good result will seldom be obtained unless a fusion of this joint be done. Tenotomy of the tendo-Achilles is by no means indicated in all cases.

Fractures of the spine have brought forth a great deal of literature and the evidence seems to point to the fact that unless the cord be impinged upon, operation is of no benefit. The best treatment seems to be hyperextension on the Bradford Frame for from four to eight weeks, this to be followed by a Taylor brace or plaster support for from six months to a year following.

Most deaths in this fracture are caused by cystitis and nephritis following catheterization. It may be definitely stated that in this class of case where there is urinary retention catheterization is contra-indicated. If left alone an automatic bladder will be established.

During the year of 1927 there have been many discussions concerning the various procedures in the open reduction of fractures. Sherman of Pittsburgh, who is an advocate of plates, states that there are but 12 hospitals in the United States equipped to handle the operation of these cases. The writer believes that this is probably exaggerated, but is also of the opinion that the various metallic plates might well be discarded entirely. We have found in all cases operated that it was possible to obtain an end to end reduction by merely approximating the fragments, closing the wound and applying a cast. In a few instances it was necessary to dove-tail or groove the ends in order to obtain a locking. The use of the plate is objectionable as it delays bone union and necessitates a second operation for its removal. Also in doing open reductions the danger of infection must always be kept in mind and if infection takes place in the plated case, it affects not only the bone ends but also the entire cortical substance to the screw holes distal to the fracture line.

In closing it may be well to state that in operating for the reduction of fractures there must be no hand contact with the wound.

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## PROCTOLOGIC PROGRESS IN 1927

L. J. Hirschman, M. D.

The specialty of proctology has continued to make great strides during the year just closed. Greater interest than ever before is being manifested in the patient suffering from diseases of the anus, rectum and colon.

Post-graduate schools report a large increase in the number of practitioners desiring special instruction in proctology. Many surgeons are abandoning general surgery in order to limit themselves to this highly specialized field.

An additional number of medical colleges and universities have provided for special teaching in proctology by proctologists. The same is true of the hospitals. The number of attending proctologists is increasing and departments of proctology inside of the hospitals as well as in out-patient departments is increasing.

The meeting of the American Proctologic society in Philadelphia in May, 1927 had the largest attendance ever recorded.

The session of the section on gastro-enterology and proctology at the Washington meeting of the American Medical association, was crowded to the doors. For the first time in its history, at the Detroit Surgical Congress of the American College of Surgeons, proctologic clinics were given every day in special proctologic departments of several hospitals. In some instances these clinics were attended by a larger number of surgeons than could be comfortably accommodated.

All of the foregoing indicates a growing appreciation on the part of the profession of the real need for the same special attention to patients suffering from diseases of the lower bowel as to those suffering from diseases of other organs.

During the past year there has been a more general employment of caudal, sacral and spinal anesthesia in the surgical treatment of diseases of the anus, rectum and colon.

Patients themselves are not only insisting upon the treatment of their proctologists but are requesting the use of one of these non-sleeping methods of anesthesia.

The public is beginning to realize that certain non-surgical methods of treatment are employed when indicated by ethical proctologists. They are learning it is safer to be treated by men who are morally responsible to their profession, to the law, and to their own consciences, than to trust their fate to the irregular, blatant and irresponsible advertising ambulant proctologist.

The type of practitioners who are limiting themselves to proctology in their various communities, represents a high average of professional integrity. These men as a rule, merit the respect and confidence of their professional co-workers and have rescued the treatment of rectal diseases from the dangerous channels into which it was drifting in the past.

Proctology is grateful to the general profession for their co-operation and promises a continuance of the earnest, ethical, scientific and conscientious pursuit of the specialty and an increasing endeavor, by its acts, and the results of proctologic treatment by proctologists, to continue to merit the approbation, respect, support and esteem of the profession at large.

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## UROLOGY

H. W. Plaggemeyer, M. D.

In the year 1900, the International Society of Chemists sat in solemn conclave, and, after lengthy and erudite discussion, accompanied by much wagging of heads, sagely declared that chemistry had reached its bounds, and that nothing more remained to be discovered in this realm of investigation. Since that time there have been more and farther reaching advances made in that one domain, than throughout the previous 300 years put together.

Ten years ago it was commonly remarked that urology had reached its limit. Nothing was left to write about. Strange to relate, it has more than kept pace with its sister specialties, not only in new discoveries, but in the application of newly discovered principles in the applied sciences. The investigations of Hinman, and of Richards and Plant, are to be regarded as of particular significance in the realm of physiological urology, while modifications in operative technique, throughout the field, have not been without interest.

The past year, has witnessed a marked advance in the field of Electrotherapeutics, and will, undoubtedly, be looked upon in retrospect, as the opening phase of a new era; for, while this branch has been for sometime diligently applied, it is really in 1927 that it has come definitely into its own. Amongst the many applications of diathermy, probably the most interesting result of the year's clinical work is the observation that its use per rectum, in cases of gonoccocal posterior urethritis seems to preclude the hazard of acute or chronic prostatitis. If, in its last analysis, this postulate stands completely proven, we have bridged a gap, hitherto thought of as impossible, and have been able to give to humanity, a distinct boon in the control of that most intractable aftermath of Neisserian infection. It needs but small exercise of the imagination to fancy some future modification of this method as a powerful weapon in the acute stage. The question as to whether this procedure has a tendency to kill spermatazoa, and to inhibit spermatogenesis is a present battle ground for two groups of physiologists and pathologists. The future alone will tell the story.

The number of new instruments and mechanical appliances is legion. The outstanding one is the Colling's Electrotome for use in the treatment of the poor maltreated fibrous contracture, or so-called median bar of the vesical neck. The other indication for its use would be, obviously, in conditions of fibrous scar after prostatectomy, particularly when done by the perineal route, and in advanced cases of prostatic carcinoma which have risen to

the dignity of median bar formation. The instrument as devised by Dr. Collings of New York, and technically perfected by Wappler, meets a long felt want, superceding, as it does, the highly unsatisfactory procedure known as the punch operation. The process is not a cauterization, but an efficient cutting under observation at every second by the operator. The instrument behind the knife is a generator of high frequency electric current of such character that, when used in conjunction with suitably designed applicators, it effects free cutting of human tissues even in a water medium. Again it is to be noted that this instrument cuts, and does not cauterize; hence there is no thick slough, and consequently no secondary hemorrhage, which was the bane of our lives under the regime of the punch operation. Primary bleeding is practically nil, and the procedure itself is a really minor one, giving relief to major lesions, apparently without grave complications. It need scarce be mentioned that this method is never employed in cases of true adenomatous hypertrophy.

Especially worthy of notice is Lowsley's new electrode for application to bladder tumors, under direct vision. This is a permanent instrument, and will undoubtedly do away with the previous expensive nuisances with which we have so long struggled. His other product of the year, is the longitudinal rongeur for picking foreign bodies from the bladder. This instrument has the peculiar advantage over its predecessors in that it enables the operator to see completely around the object to be attacked.

The new baby scope of Wappler will have immediate popular acceptance over the Helmhotz instrument, in that it is only size 11 and will freely take *two* No. 4 ureteral catheters.

In the operative field, particular attention has been given to vas ligation in prostatectomy as a preventive against epididymitis. The incidence of epididymitis without vas ligation is 20 per cent, a dangerous factor in the aged. According to Goldstein this procedure should be done in all cases, and preferably before the operation. *Ligation has no effect on the sexual powers.*

With regard to the removal of the prostate itself, the practical consideration is not the mere extirpation of the gland, but the problem of renal decompression which *should* precede it. In the perineal operation this is done by fractional catheterization, with a view to a re-establishment of an impaired renal circulation. In the past 10 years, the proponents of the suprapubic route have held rather closely to the two stage operation, using open cystotomy as the first or decompression stage, and allowing the bladder to become infected, thereby establishing its own immuntiy during this trying interval before actual removal of the gland.

Lower of Cleveland has long advocated the one-stage operation, and in this past year Thomas of Philadelphia has come out openly for it, both claiming that the catheter may just as well be employed here as in the perineal route. Their arguments, carefully reviewed, seem to carry conviction, and the writer feels confident that the year 1927 has seen the pendulum slowly and surely swing away from the two-stage, toward a one-stage operation preceded by inlying catheter and fractional reduction. Naturally cases of marked cystitis, or of tumor or stone with large blood clots have to be handled on the individual merits of the case, but we feel sure in stating that the general tendency is, except in this minor percentage of cases, toward the one-stage operation, after having satisfied ourselves that the previously impaired renal circulation has been readjusted.

In the field of chemo-therapeutics, mercurochrome has just about held its own, the present query being whether it is not of much better value in the head specialties than in the urological tract. Certainly it has proved of no use whatever in the treatment of gonorrhea, though it is only fair to say that its sponsors never claimed this for it.

Hexylresorcinal is still in the clinical experimental stage. However the work during 1927 of Leonard and his associates on surface tension, may lead us on to discoveries of far greater importance than its local application to hexylresorcinal itself.

## RESUME OF RECENT PROGRESS IN OTOLARYNGOLOGY

B. N. Colver, M. D.

In making this review the Archives of of Otolaryngology for 1927 have been used as the source. This Journal prints each month an article by some leading man outlining the progress on a given line.

*The Functional Examination of Hearing: Deaf Mutism and the Education of the Deaf*—(January)—Robert Sonnenschein, Chicago.

A great deal of attention is being paid to the study of the bone conduction, or as it is now often termed, cranial resonance. With bone conduction the sound according to Retjo travels directly to the labyrinthine

fluid. Shortened bone conduction means a pathologic condition of the labyrinth or disease of the nerve or changes in elasticity of the labyrinth fenestra.

The study of the problems of hearing by the audiometer is receiving increasing attention by many otologists. The great diagnostic value of accurate audiographs is that they show a complete picture of the hearing capacity over the whole range of frequencies for both ears.

Fowler sums up the data and value derived from accurate audiographs as follows:

Many ears believed perfect by the patient show marked defects, especially in the frequencies not used for speech.

Many abnormalities of the ears appear to be inherited and no changes may be shown during many years or throughout life. Other members of the same family may have similar abnormalities.

The already developed defects at certain frequencies, although unnoticed by the patient, may warn the examiner of impending deafness. Sufficient time has not yet elapsed for us to interpret these graphs diagnostically.

Return to normal or near normal is shown with great precision.

Failure to return to normal is most important to note, and treatment may be undertaken which otherwise would not have been deemed reasonable.

Malingering is easily detected because no one can repeatedly sense correctly a given intensity of sound.

To diagnose total deafness in one ear, it is possible to construct as a guide binaural graphs of known instances of nonaural total deafness, and compare with such guiding graphs the curves obtained from suspected totally deaf ears.

When all the data are considered, it is apparent that even normal ears do not show a straight normal line, but vary up and down, depending on time, place, barometer fatigue and noises.

*Anatomy and Physiology of the Ear*—(February)—Philip E. Meltzer, Boston.

Gross anatomy has not attracted many investigators during the past year. Considerable research, however, has been done on the finer structures and individual cells. It has been indicated that the greatest functional demand is made on the basal turn to the cochlea. There is therefore a greater physiologic predisposition to acoustic injuries. This is an area primarily affected by disease and by mechanical factors. Senile deafness also doubtless affects a basilar membrane weakened by faulty metabolism, infectious disease and other diseases.

*Peroral Endoscopy*—(March)—Louis H. Clerf, Philadelphia.

*Esophagoscopy*—Cancer—All cases of dysphagia should be examined by esophagoscopy because it is the only sure way. Oblique observation with the patient in the prone position while drinking the opaque material will keep the esophagus filled in its entire extent with a construction at the point of disease.

*Cancer of Lungs*—Any case that shows the combination of cough, occasional hemoptysis, apparent good health and the absence of obvious intra-thoracic signs, suggest new growth of the tracheobronchial tree and should be examined with a bronchiscope.

*Tumors of the Nose and Throat*—(April)—Gordon B. New, Rochester, Minn.

New concludes that the use of cautery and radium in the treatment of malignant tumor of the antrum eliminates death at operation and cures more patients than have been cured previously by an operation.

Tucker reports 15 cases in which laryngo-fissure was performed for early cancer of the larynx. He recommends the operation of early, anterior, intrinsic cancers of the larynx and laryngo-pharynx treated by the use of radium, and concludes that radium is of little value in the treatment of cancer in this region.

*Tonsils and Adenoids*—(May)—Arthur W. Proetz, St. Louis.

Based on an analysis of the complaints of 1,200 children with the results found three years later, and compared to 1,200 children with similar complaints in whom operation was denied but who were also examined three years later, the following conclusions can be made bearing on the indications for tonsillectomy and adenoidectomy:

1. Mouth breathing is a definite indication for tonsil and adenoid removal.
2. Frequent attacks of sore throat and tonsillitis offer a definite cause for removal of tonsils.
3. Frequent head colds, relieved in 75 per cent of the cases, offers a definite indication for tonsil and adenoid removal.
4. Persistent enlargement of the cervical glands, when no other cause is found, is a just cause for tonsil removal.
5. Malnutrition, when other causes have been eliminated, will be improved somewhat and therefore may be considered an indication.

6. Chronic and recurrent discharging ears are an indication for the operation.

7. Unexplained fevers, in the absence of other indications, may be a just cause for tonsillectomy; but there is no guaranty that they will not recur, unless the fever comes from an obscure tonsil infection.

8. For the prevention of respiratory infections, such as laryngitis, bronchitis and pneumonia, no positive indication exists, as the incidence of these infections was not influenced favorably or unfavorably by operation.

9. The prevention of diphtheria and scarlet fever may be considered an indication, as the incidence of these diseases was slightly less in the group operated on; and when it did occur, the sequelae were less serious when the tonsils were removed.

10. The presence of positive or suspected evidence of the rheumatic syndrone manifestations, rheumatism, chorea and heart disease, is a definite indication for tonsillectomy in view of the lessened incidence of heart disease in the group operated on.

Von Lieberman condemns such practices as slitting, wiping or forcibly washing tonsils. He advises against sewing the tonsil wound shut after tonsillectomy, but does recommend the ligation of all vessels.

Neumann regards the presence and infection of mucous glands left in or about the tonsil fossa as a possible explanation of peritonsillar abscesses occuring after tonsillectomy.

Pilot and Tumpeer have found streptococcus hemolyticus present in 97 per cent of excised tonsils in children.

Daland summarizes his observations on chronic tonsillitis as follows:

1. Latent or chronic infection of the tonsils or sinuses is not uncommon in adults.

2. Scarlet fever, diphtheria, influenza and streptococcic milk in childhood are often the primary causes of latent or chronic tonsillitis diagnosed late in life.

3. Systemic disease, secondary to chronic infection of the tonsils or sinuses, is associated with leucopenia, lymphocytosis and diminished polymorphonuclear cells in about 40 per cent of the cases.

4. The presence in pure culture of the streptococcus hemolyticus or viridans in the bottom of a crypt of a tonsil is diagnostic, the importance of which is increased when injections into animals prove that the streptococci possess pathogenicity and selectivity.

5. The presence of bacteria in sinuses possesses additional diagnostic value because these regions are normally sterile.

6. Latent or chronic sinusitis is often an unsuspected focus of infection and often co-exists with infected tonsils and teeth.

7. A negative opinion in suspected chronic sinusitis should only be given after repeated examinations.

8. Closed infected ethmoid cells may be the cause of post-operative failure, even when free drainage has been secured.

9. Autogenous vaccines are valuable in asthenia, emaciation, anemia and in the aged.

*Chronic Progressive Deafness*—(June)—J. K. M. Dickie, Ottawa, Canada.

*Otosclerosis*—Recent studies show that while there may be an endocrine factor in the production of progressive non-infectious deafness, it is only through the effect of these upon the metabolism whether this is the organic or inorganic chemical processes. This is shown by (1) the hereditary tendency; (2) gonads—preponderance in females and association with puberty, pregnancy and climacteric; (3) thyroid, in a lower metabolic rate; (4) pituitary; (5) parathyroid, by the lowered blood calcium and chronic tetany. It is also shown by other metabolic disturbances such as:

1. Fatigue symptoms.
2. Abnormality in weight.
3. Low blood pressure.
4. Subnormal alveolar CO tension.
5. High undetermined N. in urine.
6. Increase in blood nitrogen.
7. Anemia.
8. Association with other metabolic general diseases.

These processes affecting the petrous bone because of the infantile character of the chondroid bone.

*Inner Ear Deafness*—Usually associated with an unbalance in the uric acid metabolism or intake shown by a hyperuricemia and association with a gouty diathasis. Therapy is a purin free diet and cinchophen.

*Senile Deafness* — Usually associated with arterio sclerosis, hypertonus and hypercholesterinemia. An arcus lipoides of the drumhead as well as of the cornea are always found.

Treatment is concentrate on an attempt to lessen the cholesterin content of the blood. Calcium theobromium salcylate 0.5 gr. t.i.d.

*Allergyasrelated to Otolaryngology*—(November)—W. W. Duke, Kansas City, Mo.

The sensitivity to food proteins in the

serum of normal donors in case of blood transfusion is a definite contra-indication to transfusion in allergic cases.

Non-protein constituents of pollen, etc., can bring about the characteristic response (Greve and Cass).

Temporary sensitivity may be transferred to the normal individual with the blood serum of the sensitized person. Enclosure within a dustless room, while useful as a treatment, aids also in the diagnosis of the presence of irritants in the ordinary air. Continuous desensitization at progressively increasing intervals up to 30 days, gives good results replacing preseasonal desensitization (Black).

*The Paranasal Cavities* — (September) — D. Campbell Smyth, Boston.

Non-suppurative (hyperplastic) sinus disease is present in the majority of intrinsic reflex asthma cases (Mullin). The maxillary sinus is very often affected (Hirsch), whereas the ethmoid has been chiefly considered. The diagnosis is complicated by the fact that transillumination is usually clear. Certain cases where sensitive nasal spots are found are most suggestive of relief by nasal treatment (Coates). Otherwise the sinuses rank as bacterial foci as do teeth and tonsils. Only radical surgery of the affected sinuses averts recurrence of polypi and abates the irritation (Mithoefer). In the maxillary sinus complete removal of the mucoperiosteum is usually advised. Pre-operative knowledge of pathological anatomy, as governing the choice of operation, and a desire to discover all affected sinuses, are making demands on diagnostic measures. This is successfully met in the roentgenologic field by introduction of raidopaque oils. Opaque injection (Fraser), and displacement (suffusion) of Proetz of the various sinuses, coming into common use, producing statistics valuable to prognosis and to the selection of the minimum effective surgical treatment. The corresponding introduction of therapeutic solutions, in inverted positions of the nose, which enter the sinuses upon pressure variations applied to the closed nostril, opens a new field in treatment. Ephedrin, hydrochloride and sulphate ½% are most efficient used in this way.

The list of body systems showing disturbances or lesions due to paranasal sinus disease, even without suppuration, is being augmented. Ide reports a psychosis cured by sinus surgery.

*Acute and Chronic Otitis Media and Sinus Thrombosis*—(August)—Samuel J. Kopltzky, New York.

Spielberg has studied the Eustachian tube on roentgenograms by injecting iodized oil. This knowledge is of value in radical mastoid operations where a part of the procedure is turned to the task of closing the Eustachian tube.

Porter's report on the intravenous injection of mercurochrome—220 soluble in the treatment of patients with otitic sepsis. His results have been good in the four cases in which he employed it. His procedure is as follows: If the patient is very septic, the maximum dose (5 mg. per kilogram of body weight) is not given; instead he gives 3 mg. per kilogram of body weight, repeating the dose after a short time. He feels that small doses allow a gradual load to be thrown on the kidneys, which can be cared for without difficulty. The drug should be given when the temperature is falling rather than when it is rising. In addition, if the red blood cells are below 2,500,000, whole blood transfusion should be given at the same time or before the mercurochrome is administered.

Woodhouse, in a study of 74 cases of chronic purulent otitis media associated with polyps, treated the patient by simple removal of the polyps. In the 48 cases which he was able to follow up, he noted a cessation of the discharge in 62.5 per cent; in 25 per cent of these 48 cases no recurrence of the polyps occurred, although the ear remained moist. The remaining patients were unimproved. He recommends the removal of the polyps in all cases of chronic purulent otitis media when no other complications exist, before resorting to the radical mastoid operation.

Much of the literature on acute otitis media is devoted to the occurrence of this condition in infancy.

Drury advocates the removal of adenoid tissue without administering anesthesia in cases of purulent otitis media in infants. Souper advocates the removal of both the tonsils and the adenoids in the treatment of a patient with otitis media following scarlet fever. Both these observers base their conclusions on the opinion that these procedures shorten the course of the otitis.

Hastings and Cullom stress the examination of the rhinopharynx in cases of otitic infection and the necessity of eradicating purulent foci in order to hasten the cure of the aural suppuration.

# MONTHLY COMMENTS

Medical—Economic—Social

For some time the American College of Surgeons has been stressing the need of establishing fracture services in hospitals. Inquiry made at the headquarters of the college is answered by the statement that they have no list of hospitals where such services have been created nor have they any detailed recommendation as to what the procedure should be to establish such a service. It would seem that the college might well formulate methods and policies ere urging hospitals to institute such new services. It is easy to recommend but more difficult to accomplish the recommendation. We would like to hear if such service has been created in any Michigan hospital and if so what constitute the governing regulations.

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There are far too many medical books and papers being written. If one scans medical journals he will find many, many mediocre articles, of little passing value and poorly written. To write a good paper requires more than a typewriter and a hasty transcribing of passing thoughts. We are not discouraging the writing of articles. We simply note that few men take time to write, to boil down their writings and compile necessary references. We do believe, however, that every doctor has at least one case a year that merits reporting with a brief comment thereon. We solicit such reports for The Journal.

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Our State Commissioner of Health, Dr. Kiefer, has once more evidenced his ever willingness to co-operate with the doctors in the administration of his department of health. In this particular instance the examination of chauffeurs of public vehicles is delegated by law to the State Department of Health. This required the appointment of local examining physicians. In place of appointing one man in each city and county, Dr. Kiefer has adopted the liberal policy of accepting the report of physical examination made by any doctor who is a member of his County Medical Society. Value of membership in your County Society is thus again enhanced.

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We are devoting considerable space in this issue to impart the views and opinions that were given at the dinner at the Michigan Union at the time of the University Hospital Clinic, held in November. We are quite sure that the mutual sentiment evidenced reveals the profession's interest in post-graduate education and that as this interest increases desired facilities for post-graduate study will be developed in Michigan. We confidently look forward to the development of one or two clinics and schools within our state where our members will be accorded excellent opportunity for continued study at stated intervals.

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January brings taxes. Preachers, lawyers, plumbers are permitted to deduct from their income expenses incurred in attending state and national meetings. This is denied to doctors. Just why the discrimination no one knows. For two years the A. M. A. Bureau on Legislation has been endeavoring to secure a change in this ruling. By persistent diligence, signs are now hopeful that this ruling will be altered. It is hoped that the change may be authorized in order to apply on 1927 returns.

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Last month we imparted some figures on the "Cost of Being Born." Doctors have been blamed for the apparent increase. If you checked over the figures we wonder if you noted in the one cited case where the cost was given as $430.24 that the doctor only received $50.00 and in the $888.26 case the specialist only received $150.00. Our economists might well stress the fact that the high cost of "borning" is not chargeable to the medical profession.

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Happy New Year. Here is hoping that the fullest measure of happiness shall be yours throughout 1928.

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January, with its long evenings, will afford you opportunity for engaging in a sustained course of reading. Get out your Journals, recent textbooks and reprints and with the old pipe equal the time you spent on the golf course or fishing by "catching-up" on your neglected reading.

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Dues! Your 1928 dues are now payable. Get it off your chest by sending your check to your County Secretary today. Relieve your local Secretary of having to camp on your trail by prompt payment. Your annual dues bring you greater returns than any other investment you own.

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Life insurance companies still seek to impose upon doctors and endeavor to obtain free medical opinions relative to applicants for insurance. Today we again encountered such an incident wherein a company wanted to know what our findings were and prognosis following a laporotomy in an applicant for insurance. We requested the agent to pay a consultation fee before imparting the information, telling him that we never gave opinions to insurance companies without remuneration. Incidentally we imparted our opinion of corporations who thus grafted on doctors. The agent informed us that insurance companies would continue to secure such free information and opinions as long as doctors were willing to give free advice. And there you are—we repeat anew; you are an "easy mark" doctor, if you continue to give free information and opinions to insurance companies. When the request comes, return the letter with the notation that you will impart the desired information as soon as they send you a check. Don't let 'em talk you into it by saying your attitude is depriving the individual from obtaining insurance. You are not, for agents do not as a rule let a prospect get away so easily. Demand your fee, get it in your mit before giving information. We got our ten spot and during the year we secured several such fees. Of course, if you want to be a "fall-guy",

that's different. On the other hand, such a fee now and then helps to buy gasoline and removes you from the "easy mark" class. You can determine your own classification.

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If you want to go to Europe there are plenty of scheduled trips listed that will afford you much pleasure and enable you to see the old world with enjoyment. We discourage clinical tours, for from a scientific and profit standpoint they are of little value. Our American clinics will teach you all you can possibly absorb and apply in your work while clinic tours will profit you very little. Tour for pleasure, not for study. Do your studying in your own neighboring clinics in this country and enhance it by attending the meetings of your county, state and national organizations.

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There is an occasional criticism voiced, but spreading, arraigning periodic physical examinations. The discussion is more frequent among the laity. The criticism is that the examination does more harm than good. It is based upon the assertion that when an individual following such an examination learns that he has a beginning hypertension, arteriosclerosis, some kidney change, or minor heart defect, the gaining of that knowledge has such a psychic effect and depression and deprive him of ignorant bliss through a period of years, in which he might work free from worry, ere his condition progressed to disablement. Benighted fools, elevating ignorance over truth, when truth means increased span of life. However, such critics exist, evidencing anew for a continuation of our public education with increased intenseness. We wonder, though, if the criticism did not eminate from the scientists and cults and thus evidence the ulterior motive of pursuers of such follies.

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The importance of prompt payment of dues was again made apparent this past month. A member failed to pay his 1927 dues until November, 1927. Consequently he was not in good standing from April to November, 1927. In December, 1927 suit was begun against him for services rendered in September, 1927—while he was in suspension as a member. Under our medico-legal rules defense can not be furnished to him. Hence his dereliction in failing to pay his dues will entail his employment of an attorney at a fee that would have paid his annual dues for twenty to thirty years. Neglect in failing to promptly pay annual dues may be as costly to you for you, too, are ever liable to have some disgruntled patient connive with an attorney and start suit. Hence we urge that your check for current dues be promptly mailed to your County Secretary.

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# OUR OPEN FORUM

Affording Opportunity for Personal Expression

### THANKS

Editor of The Journal:—

I have just finished reading your "Season's Greetings" to the members of the State Medical Society. May I as one of the humble members offer to you my thanks for all the hard work you have done to help make the Society what it is.

With the "Compliments of the Season" and best wishes for a very Happy and Prosperous New Year, I am

Fraternally yours,
William J. Stapleton, Jr.

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### DEER HUNTING

Editor of The Journal:—

Having been one out of the 70 members who returned their cards as unable to attend the University Clinic, with the notation, "Going deer hunting," and after reading your article in The Journal, December issue, asking for a report on our outing, it is with pleasure that I send this report to you.

Our party, consisting of Mr. and Mrs. Glen Wilson, Mrs. W. Hornsby, and baby Roberta Lucile, aged 3 years, and myself, left Clinton on November 10th, and drove to St. Ignace that night, and the next day, Friday, we landed on Neebish Island, where we were joined by Mr. A. E. Oliver, aged 67 years, Mr. and Mrs. George Oliver of Plainwell, Mich.

The next day we settled down to a quiet rest and recreation after our long drive, with a nice warm cottage, plenty of good dry wood piled high on the back porch, good stoves and beds, thanks to Mr. Henry Theibert, and for our wait until the morning of the 15th.

A word about Neebish Island. Neebish Island is situated 18 miles south of the Soo, between the channels of St. Mary's river, on the east and west, with Sugar Island on the north and Drummond Island and St. Joseph's Island on the south and southeast. A beautiful place when the snow is on the ground around the edges of the water, but a wilderness when you leave the shore line and penetrate the swamps and lowlands on the inside.

It snowed the day before the season opened, then rained and froze, forming a crust, that could be heard by a dear a mile away, making very difficult walking. Every night the crust froze a little harder, and near the close of the season, the crust was frozen hard enough to hold a man up, also the deer. Imagine on the night of November 30, we had the best snow fall of the season, but it had come one day too late for us, just right for the deer.

It was the slipperiest fall in the history of the woods, and if the boys didn't fall a number of times daily they thought something was wrong, in fact, ice skates would have come in handy.

Our first week of hunting was very poor and the first man to bring home the bacon was Glen Wilson, and he brought in a 10-point buck on the eighth day. That made us feel better, and on the ninth day I dragged in an 8-point buck and so the chase was on. Then for the next few days we didn't get anything, but always when we came in at night, we found a good hot steaming supper

ready for four hungry men, but we kept hunting and on the 29th of November George Oliver killed a nice 4-point buck, and that left dad, so we placed him on runways while we three acted as dogs, and to save our lives we couldn't run those pesky old bucks out of the swamps, so dad could get a shot, and consequently dad had to come home without his deer.

We saw lots of does and fawns and they seemed to know that they were protected, as they were in no hurry to get out of gun range, but the nimble bucks seemed to know what was in store for them, for if you saw a flag you was a lucky man as they made their getaway, like the thief at night, sly and quiet.

We did not see many partridge or snow shoes and the natives on the island told us that the coyotes and wolves had about cleaned them out, and lots of times, in tracking deer, you could see a coyote track following the deer's track and several of the natives said the coyotes would kill the fawn, provided the mother doe didn't keep them whipped away.

Our party was not in favor of changing the dates for the opening of the season, but rather in favor of allowing a man a doe, providing he killed her accidentally, and could prove that it was an accident, rather than let her lay in the woods and spoil. We saw several such does killed and all spoiled for consumption.

Our party had a splendid time and at night after an all day hunt and a rousing good supper, we would enjoy the evening with the ladies, playing cards and cribbage.

And last, but not least, I must say that Dad Oliver was a good sport and a true woodsman, as he enjoyed the hunting fine, and although he came home with his metal tag in his vest pocket, he said, "I hope I can come back next year and I'll show you boys."

If you could manage to have the University Clinic, say November, first week, I am sure you would not get the returns on the cards as you did this year, and we 70 men would say "YES" we will be there.

You can print this or do as you want to with it, as I am only doing as you asked.

Very truly yours,
W. B. Hornsby, M. D.

### EXAMINATION OF CHAUFFEURS

Editor of The Journal:—

I am sending you two hundred applications for health certificates for chauffeur's license and 20 of them to the secretary of each county branch of the Society.

In all probability some physicians will have only one or two chauffeurs to examine and will want blanks in a hurry, in which case they may be supplied by you or their county branch.

Yours very truly,
Guy L. Kiefer, M. D.

### POST-GRADUATE INSTRUCTION

I am enclosing a clipping from last night's Detroit News regarding the annual meeting of the Highland Park Physicians' Club.

I spoke upon the point of a great post-graduate school of medicine where the members of the state profession could obtain experience in most any way that they might choose. Also that a more experienced, better qualified and better equipped medical profession for Michigan meant better service to its citizenry with a healthier population and longer lives. That well trained men in different localities of the state would mean that much medical work would be done locally and that our state would be relieved of a portion of its medical burdens.

Hoping that this matter may be worked out to the satisfaction of the state profession,

Yours very truly,
Angus McLean, M. D.

# NEWS AND ANNOUNCEMENTS

Thereby Forming Historical Records

A Happy New Year. Start it right by reading this issue and then watch for each monthly issue. Some interesting articles and announcements will be found every month.

If it were not for our advertisers this Journal would not be possible. In return for their patronage you owe them your patronage. Peruse our advertising pages, answer the ads offering literature and samples and place your order with those who are able to efficiently fill your orders with dependable products.

## WAYNE COUNTY MEDICAL SOCIETY

Program for January, 1928

January 3. General Meeting.

1. Election of State Delegates.
2. Address. Subject—"Colloidal Chemistry in Its Relation to Medicine." Professor Harry N. Holmes, Oberlin College, Oberlin, Ohio.

January 10. Medical Section.

1. Report of a case of incarcerated right paraduodenal hernia. Dr. Edward Dowdle.
2. Address. Subject—"Neuro-Surgery in Modern Practice; Prognosis, Diagnosis and Treatment." Dr. F. C. McClintic, Professor of Anatomy, Detroit College of Medicine. Discussion—Dr. Max Peet, University of Michigan, Ann Arbor.

January 17. General Meeting.

Subject—"Physical Treatment of Diseases of the Circulatory System." Professor Franz Groedel, Bad-Nauheim, Germany. Illustrated.

January 23. 8:30 p. m.—Beaumont Lectures.

Lecture 1—"The Human Constitution—What It Means and How to Study It." George Draper, M. D., New York City.

January 24. 11:00 a. m.—

Lecture 2—"The Patient and His Physician." George Draper, M. D.

January 24. 8:30 p. m.—
Lecture 3—"Sex Factor in Total Personality." George Draper, M. D.

January 31. General Meeting.
In charge of Entertainment Committee.

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The Detroit Oto-Laryngological Society are planning an excursion to the Mayo Clinic for a two days' meeting there.

They are to leave Detroit at noon Sunday, January 22nd, and spend Monday and Tuesday at Mayo's, where a special program is being prepared for them.

Wednesday will be spent in Chicago. The return to Detroit will be made in time for work Thursday morning, January 26th.

Those throughout the state who wish to join this party should get in touch with the Secretary, Dr. Wm. Fowler, 1048 Maccabees Bldg., at once.

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The Highland Park Physicians Club will hold its next regular meeting in the nurses' dining room of the Highland Park General Hospital on Thursday, January 5, 1928, at 8:30 p. m.

Subject—"The Relation of the Emotions to Disease," by Dr. Carl Camp, Ann Arbor, Professor of Neurology, University of Michigan Medical School.

The members of the Michigan State Medical Association are invited to attend.

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## DEATHS

Dr. Arthur E. Schnell, 57 years old, died November 29th following an illness of several months. He had practiced medicine in Detroit for the past twenty-three years.

Dr. Schnell was born in Rochester, N. Y. and was educated in New York City and received his degree from the St. Louis University. He was a member of the Wayne County Medical Society and the Michigan State Medical Society.

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## WOMANS AUXILIARY, MICH. STATE MEDICAL SOCIETY

MRS. GUY L. KIEFER, *President*
Lansing, Mich.

MRS. J. EARL McINTYRE, *Secretary*
Lansing, Mich.

### THE WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

The Woman's Auxiliary to the American Medical Association is an organization composed of the combined membership of the State Auxiliaries, which in turn are made up of Auxiliaries to County Medical Societies.

The first Auxiliary was formed in 1917 at Dallas, Texas. Out of that grew similar organizations all over the state. In 1919 a State Auxiliary was organized in San Antonio, Texas.

Other states became interested in the work and in St. Louis, 1922, during the meeting of the American Medical Association, the matter of forming a National Auxiliary was presented to the House of Delegates. It was endorsed by that body and the Woman's Auxiliary to the American Medical Association was organized, with nine states enrolled.

It is now in its fourth year of national activity, having twenty-seven states already organized, with others in the process of organization—more than half the states in the union!

Where there is a County Medical Society there should be an Auxiliary. It has been uniformly noted that there is more interest and enthusiasm, and a greater spirit of comradeship among the members of the County Medical Society if there is an active Auxiliary working in the community.

The National Auxiliary does not attempt to dictate, but desires to co-operate with all Auxiliaries in carrying out their work.

The object of the Woman's Auxiliary to the American Medical Association is to be all that its name implies—an aid, a reserve force—an Auxiliary! Organized for the purpose of responding to any call from the medical profession.

To do all the work assigned to it from time to time by the American Medical Association.

To promote closer contact between the families of physicians.

To assist in lightening the burdens of humanity.

To help preserve the health of the people.

The members of the Woman's Auxiliaries to the American Medical Association are those who have paid their annual dues to the National organization through their County and State Auxiliary.

Where there is no local Auxiliary a physician's wife may become a Member-at-Large by paying annual dues of $2.00. Wives of the members of the Medical Corps of the Army, the Navy, and the Public Health Service are especially invited to become members-at-large, if it is impossible for them to have county affiliations.

Each state sends its Auxiliary president and president-elect, two delegates and their alternates to represent it at the annual session which meets at the same time as the American Medical Association.

Every phase of the work is first passed upon by the executive board, which meets just before the annual session. After the election of officers, the new executive board is called together to hear the plans outlined by the incoming president.

Another called meeting is usually held in the fall before the activities begin. Matters of immediate importance should be referred to the president and members of the liaison committee. This committee is appointed by the trustees of the American Medical Association.

For this year the National Auxiliary Board has accepted the following recommendations from the president:

To organize Auxiliaries in unorganized states and to urge all state presidents to form Auxiliaries wherever there is a County Medical Society.

To outline health programs approved by the liaison committee to be presented before other organizations.

To secure, if possible, moving pictures to illustrate the importance of the annual physical examinations by the family physician. Each member of every household, servants included, should be examined.

To recommend to all clubs that they place capable physicians' wives in charge of club health departments, in order to secure authoritative programs.

To assist in providing Health Talks over the radio by prominent physicians and health officers. These speakers should be appointed by the County Medical Society.

To continue our efforts to place Hygeia in every home, as it is the leading health magazine of the United States and is published by the American Medical Association.

To appeal especially to physicians to aid in the Hygeia campaign, as the commissions received enable the Auxiliaries to extend their activities.

To suggest Hygeia subscriptions as Christmas gifts, and also as gifts to expectant mothers. The helpful, healthful suggestions she finds in Hygeia are more lasting than perishable flowers or breakable toys.

To recommend to Auxiliaries that they give benefit entertainments to create a fund for Hygeia, which will be used as gifts of subscriptions to schools, legislators, churches and libraries.

Hygeia has offered to give subscriptions to the magazine as prizes for these entertainments.

To publish our own Bulletin monthly in order to keep alive the interest of the members, and to present the work to physicians' wives who are not yet familiar with Auxiliary activities.

In order that the greatest possible good shall be accomplished it is necessary that the Woman's Auxiliary to the American Medical Association have the full co-operation of all the members of the American Medical Association and their wives. It is the earnest endeavor of the Auxiliary to bring its work to the attention of all who are interested in the welfare of our people.

Every physician's wife should feel it a privilege as well as her duty to promote dependable health education, not leaving it in the hands of those who are interested in spreading the propaganda of various cults.

She can aid materially in the Auxiliary's effort to impress upon all club members a proper conception of the real mission of organized medicine, especially in its crusade of Preventive Medicine.

She may gain much from her club activities, but she can give even more to her club co-operating with the Auxiliary in its health education program.

A woman forfeits none of her own happiness nor her family's when she lends her time and influence beyond the confines of her own household. Her power is made greater and her outlook on life clearer by her contact with other women.

### HOW STATE AUXILIARIES ARE ORGANIZED

It is useless to try to interest the wives unless their husbands believe in the Auxiliary.

A member of the national organization committee should be invited to appear before the House of Delegates. If the Auxiliary receives the endorsement of that body, the state president of the Medical Association then appoints the capable wife of a physician to assist the organizer in calling together the wives of physicians who are attending the meeting. If they vote to organize an Auxiliary the officers are elected and the newly elected president appoints her committees.

Ordinarily the officers are: President, president-elect, four vice presidents chosen from each section of the state; secretary, treasurer, auditor and parliamentarian.

The president appoints her own corresponding secretary.

The standing committees may be organization, finance, health education, Hygeia, program and public relations.

The chairmen of these committees, the officers and state presidents constitute the executive board, which should meet and discuss plans for the year.

At first the most important work is the organization of Auxiliaries to the County Medical Societies over the state. The state president of the Auxiliary should write a letter to each president of County Medical Societies to ascertain if they desire an Auxiliary. If the Medical Society endorses the Auxiliary, one of the state organizers is put in touch with the wife of one of the members of the County Medical Society who will call the wives together for organization. If possible, the chairman or some member of the organization committee meets with the physicians' wives to aid them.

It is recommended that each Auxiliary send its president-elect and two delegates and their alternates to the annual session which meets at the same time as the State Medical Association.

### ACTIVITIES

The work of County Auxiliaries may be divided into three groups—social, philanthropic and educational. Each group may be headed by a vice president.

Auxiliaries should meet each month from October to June, making reports and recommendations.

In addition to the reports of the committees, a paper may be read or a speaker provided to address the members on subjects of particular interest to them.

A social hour may follow with light refreshments.

### SOCIAL GROUP

This group may be divided into the following committees: Membership, telephone, courtesy and entertainment.

The membership committee keeps the members active in securing new members. This committee visits the wives of members of the County Medical Society, enlisting interest in the local work.

The telephone committee divides the membership, each taking an equal number of names; it is their duty to telephone each member at least one week in advance to remind them of the time and place of meeting, and to ascertain how many can attend. The lists of acceptances are turned over to the chairman of the entertainment so that she may know for how many to provide. The chairman of the telephone committee informs the members of the executive board of their meetings.

When the Medical Society wishes some prompt service from the Auxiliary, the telephone committee can get the information to the entire membership within a few hours.

The courtesy committee calls upon the wives of physicians soon after they become members of the County Medical Society.

If a member is ill or bereaved, this committee lends its sympathy and service. Visits are made also when out-of-town physicians' families are ill in local hospitals. Courtesies are extended to wives of physicians while they are visiting the city.

The entertainment committee may select the place of meeting, appoint hostesses for the season, and provide refreshments, except when an individual member wants to entertain. Each member may be assessed her pro rata for the entertainments, or it may be added to the dues for the year. The refreshments should be light and within the means of all the members.

The first meeting of the season may be an afternoon tea given in honor of the officers. The president makes a short talk and announces committees which she has appointed to carry out the plans for the year.

Near the holiday season an evening affair may be given in honor of the president and officers of the County Medical Society.

The last meeting of the season may be an afternoon program given in honor of the mothers of the physicians.

The annual reports and election of officers may come before the program.

When there is a state or a national medical meeting, the entertainment committee co-operates with the County Medical Society committee in providing entertainment for the visitors. In cases where the details were left entirely to the Auxiliary entertainment committee, it has been found satisfactory and less expensive.

### PHILANTHROPIC GROUP

This group is divided into as many committees as are necessary to carry on the work as outlined by each individual auxiliary.

It is recommended not to undertake too much at first, but to increase the activities as the interest grows. There is always more to be done than there are funds available with which to "carry on". Each Auxiliary selects the greatest need of its community and undertakes to make its influence felt by co-operating in every possible way with charitable enterprises of the city.

Committees and sub-committees undertake the following:

To visit all the charity wards of the hospitals, taking fruits, flowers, etc.

Books and toys are taken to the Children's Hospitals, and a story hour provided for the convalescents.

Layettes are made for needy mothers.

Showers of linen and clothing are given for the Baby Hospitals.

Surgical dressings and aprons made for doctors and nurses in their charity work.

Gowns and bedjackets for Tuberculosis Hospitals.

Visits are made to institutions for the aged, furnishing them with diversion and entertainment.

Soldiers, old and young, are provided with games, radios, victrolas, edibles, automobile rides, Christmas trees, etc.

A milk fund is provided for undernourished school children.

Healthful school lunches prepared and served to school children at minimum cost.

First aid tents furnished Boy Scouts, rest tents for Salvation Army camps.

Stockings filled and sent to Empty Stocking Crusade, Christmas boxes furnished Red Cross for distribution.

Donations to Community Chest.

Loans to needy physicians' families.

### EDUCATIONAL GROUP

This group consists of two important committees—education and program—and as many subcommittees as are needed to carry on the work.

The program committee selects the subjects to be discussed at each meeting and provides the speakers.

This group prepares a tribute to the members who die during the year, which is read at the last meeting of the season.

They assist in providing prominent and able speakers on the radio.

Outline campaigns for securing birth registraitons.

Co-operate with Chambers of Commerce and their health programs.

Furnish reports each month of current events in medical progress.

Interest boys and girls in giving health plays in schools.

Co-operate with health officers in their work, especially in rural districts.

Furnish good speakers to go before clubs to present health programs with moving picture illustrations.

Create sentiment for County Health units.

Assist legislative committees of County Medical Societies, when needed, in promoting good health measures—but carefully avoiding participation in any kind of politics whatsoever, except upon the recommendations of the local county or state medical organization or the liaison committee to the Auxiliary.

The health education committee makes a study of the subject to be discussed throughout the year.

Health laws pertaining to county and state.
What constitutes pure milk and water.
Food and sanitation.
Midwife problems.
History of medicines.
Lives of great physicians.
History of American Medical Association, etc.

They offer scholarships to sons and daughters of physicians.

Gives prizes for the best:
Essay on Health.
Physical test of school children.
Sanitary school buildings.
Best drilled R. O. T. C.
Boy Scout who makes best physical record.
Cleanest block in city.

### SOLICIT HYGEIA SUBSCRIPTIONS

It is recommended that Auxiliaries assist in providing homes with libraries where County Medical Societies can meet.

# COUNTY SOCIETY ACTIVITY

Revealing Achievements and Recording Service

## BAY COUNTY

The following are the newly elected officers of the Bay County Medical Society:

President, Dr. E. F. Crummer, Essexville, Mich.

Vice President, Dr. H. P. Lawrence, Bay City.

Secretary-Treasurer, Dr. L. Fernald Foster, Bay City.

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The annual meeting of the society was held Wednesday, December 14, at 7 p. m., at the Wenonah hotel. It was the largest attended meeting recorded by the society, 52 members being present.

The complimentary banquet of retiring president, D. T. Smith, was followed by the reports of committees and officers.

At the same hour the Ladies' Auxiliary of the society was formed in another meeting at the hotel. Thirty-two women were present and the following Auxiliary officers elected:

President, Mrs. A. W. Herrick.
Vice president, Mrs. P. R. Urmston.
Secretary-Treasurer, Mrs. A. D. Allen.

The following officers of the Bay County Medical Society were elected for the coming year:

President, Dr. E. F. Crummer.
Vice President, Dr. H. P. Lawrence.
Secretary-Treasurer, Dr. L. Fernald Foster.
Delegate, Dr. D. T. Smith.
Alternate, Dr. V. H. Dumond.

L. Fernald Foster, eScretary.

## HILLSDALE-BRANCH-ST. JOSEPH CO.

The regular joint meeting of the Medical Societies of the counties of Branch, St. Joseph and Hillsdale, was held at the Mitchell library on Friday evening, December 9, 1927, at 6:30. After an excellent dinner at the Lantern Tea Room, the meeting was at once called to order by the president, Dr. H. C. Miller, who introduced the speaker of the evening, Dr. H. Alexander of the University of Michigan. Dr. Alexander addressed the societies on "Phases of Thoracic Surgery" in a most instructive manner. He called attention to the danger of premature and ill-considered operations in some cases and of procrastination and timidity in others; with general description and technic of operations on the chest, including some considerations of heart lesions and traumatisms.

Much of the information brought out was entirely new; not found in text books and derived from experience gained during the World War. He covered the whole vast subject in a general way as far as possible in the time at his disposal.

Dr. Alexander was warmly thanked by the president in behalf of the Societies for his timely and most instructive address.

The subject of Public Health was then taken up and it was moved and supported "That the Hillsdale County Medical Society once more go on record as favoring the employment of a full-time Health Officer." Carried unanimously.

Moved, supported and carried, that Dr. Sawyer be made chairman of a committee of three, his associates to be chosen by himself, to formulate plans for a community clinic to examine defective children found by the county nurse, Mrs. Barnstead, in her rounds, and recommend that their parents place them in care of their family physicians for treatment in such cases are are not already under treatment.

Moved, supported and carried that Dr. Fenton be made delegate to the "Conference for Race Betterment," to be held at the Sanitarium, Battle Creek, January 2 to 6, 1928, and directed to give a report of the proceedings of the conference to the Society.

Adjourned.

D. W. Fenton, Secretary.

## IONIA-MONTCALM COUNTY

At the annual meeting of the Ionia-Montcalm County Medical Society, held at Belding, Thursday evening, December 8, the following officers were elected:

President, Dr. F. A. Johnson, Greenville.
Vice President, Dr. H. M. Maynard, Ionia.
Secretary-Treasurer, J. J. McCann, Ionia.
Delegate, C. H. Peabody, Lake Odessa.

H. M. Maynard, Secretary.

## LENAWEE COUNTY

The regular meeting of the Lenawee County Medical Society was held on the evening of November 22, 1927, at the Lenawee hotel in Adrian.

The meeting began with a chicken dinner at 7 p. m., and the scientific meeting followed.

The meeting was called to order by the President, who introduced the speaker, Dr. Arthur E. Schiller of Detroit. He gave an informal talk on the "Etiology, Diagnosis and Treatment of the Different Forms of Epidermophytosis." Dr. Schiller illustrated his talk with a few excellent lantern slides.

There was a meeting of the program committee after the meeting and an outline program was arranged. The program will be published in The Journal at a later date.

R. G. B. Marsh, Secretary.

## GRATIOT-ISABELLA-CLARE CO.

The November meeting of the Gratiot-Isabella-Clare County Medical Society was held in the Park house, St. Louis, Thursday, November 10. Supper was served to 19. The speaker was Dr. Carl E. Badgley of the University Hospital. Subject, "Fractures of the Upper Extremity." Beginning with the fingers, the doctor took up each fracture in detail, both as to reduction, and after treatment, showing X-ray pictures as he went along. Needless to say, the doctor made the subject very interesting and instructive.

E. M. Highfield, Secretary.

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The December meeting of the Gratiot-Isabella-Clare County Medical Society was held in the

Park house, St. Louis, December 8. Supper was served to 15, after which the following officers were elected for 1928:

President, W. E. Baestow, St. Louis.
Vice-President, A. D. Hobbs, St. Louis.
Secretary-Treasurer, E. M. Highfield, Alma.
Delegate, C. F. DuBois, Alma.
Alternate, M. J. Bridge, Ithaca.

Doctor Edward Cathcart of the G. U. department of the University Hospital then talked to us on the "Obstructing Prostata." Some expected this to be a pretty dry subject, but Doctor Cathcart made it very interesting, occasionally injecting a little humor along with some very practical directions on how to manage patients with prostatic obstruction.

E. M. Highfield, Secretary.

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I have been requested by Dr. Ullrich, president of our society to send you a resume of the work of our society for the past year. Irrespectfully submit the following:

January meeting address: "Diverticula", Dr. Hugo Freund.
February meeting address, "Skull Fractures", Dr. Chas. Kennedy.
March meeting address, "Public Health", Dr. E. G. Folsom.
April meeting address, "Malignant Disease", Dr. Angus McLean.
May meeting address, "Treatment of Syphilis", Dr. Geo. V. Rhee.
June meeting address, Business meeting.
October meeting address, "Gastro-Int. Conditions", Dr. F. Steinbach.
November meeting address, "Etiology, Course and Treatment of Nausea and Vomiting of Pregnancy", Dr. Jos. N. Scher.
December meeting address, "Public Health', Dr. Don. Griswald.
Election of officers.
The following were elected for 1928:
President, Dr. R. W. Ullrich.
Vice-President, Dr. A. B. Bowers.
Secretary, Dr. Jos. N. Scher.
Treasurer, Dr. W. H. Norton.

Joseph N. Scher, Secretary.

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## CALHOUN COUNTY

The year 1927 has been characterized in the Society by an increased average attendance at all the meeting. This has been largely the result of the efforts of the program committee, in bringing to our sessions some of the best talent available.

The most impelling force in producing good attendance records is the quality of the programs. Given a program of the highest sort obtainable, and there are really very few who cannot attend.

Based on the attractiveness of the programs, the following record shows who our most attractive speakers were the year just past:

1. January Meeting—J. B. Jackson and F. C. Warnshuis ..... 57
2. February Meeting—George E. McKean and Dr. Sleight ..... 54
3. March Meeting—E. P. Joslin ..... 88
4. April Meeting—F. H. Albee and A. C. Selmon ..... 90
5. May Meeting—Genito-Urinary Symposium 49
6. June Meeting—Kalamazoo Country Club Meeting ..... 56
7. September Meeting—J. D. Bruce, Ann Arbor ..... 48
8. October Meeting—E. L. Cornell and J. M. Neilson ..... 37
9. November Meeting—C. C. Sturgis, Ann Arbor ..... 41

The attendance for the nine meetings held thus far this year averages 55 per cent of the total membership. An attempt has been made to cover the main divisions of medicine, which gives variety to the papers, and with no repetition of papers by the different speakers.

The Society has sponsored the organization of the Women's Auxiliary, and this body is now well enough organized to take care of itself. It plans to hold its meetings quarterly.

The Pupblic Haelth Education Committee feel that this work can perhaps be best carried on through the medium of the health magazine, "Hygiea," and have subscribed for 249 copies of this journal for all the schools and libraries of the county.

The members added this year are six in number, as follows:

H. F. Becker, C. G. Fahndrick, Ross R. Hilborn, Caroline Hilborn, Amos J. Rivers, Wilma C. Weeks.

The deceased members for 1927 are as follows:

W. E. Doran, Sven Jesperson, *H. M. Dunlap, *W. E. Dockery.

*Former members.

Dr. L. D. Funk has resigned from the Society, and Dr. E. A. Oakes has removed from the county.

Treasurer's Report: Disbursements—

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|---|---|
| Entertainment—Guests and speakers | $ 107.85 |
| Printing Bulletin | 114.95 |
| Postage, telephone and telegrams | 29.65 |
| Per capita of $10.00 to State Society | 1,070.00 |
| Stationery and printing | 25.50 |
| A. M. A. Directory | 12.00 |
| Flowers | 3.00 |
| Hygiea subscriptions | 349.65 |
| Secretary's fee | 50.00 |
| Total | $1,762.60 |
| Receipts— | |
| From former treasurer | $ 199.53 |
| From 107 members dues | 1,605.00 |
| Total | $1,804.53 |
| Balance on hand | $ 41.93 |

Minutes—The November meeting of the Calhoun County Medical Society was held at the Post Tavern at eight o'clock, following a dinner, which was attended by 25 of the fellows.

Secretary's report as printed in Bulletin was adopted, and the following bills were read and ordered paid: Phoenix Printing company, $11.25; Secretary's office, $3.50.

The name of Dr. Edwin Hansen was proposed for membership. His application was signed by Dr. J. E. Cooper and Dr. J. J. Holes. On motion the application was referred to the Membership Committee.

The County Board of Supervisors extended an invitation to the Society to hold a medical meeting at the County Hospital, and it was moved that this invitation be accepted for the January meeting. Carried.

Dr. Hafford, speaking for the Albion physicians, invited the Society to hold a meeting in Albion at some future time; the details to be worked out by the Program Committee.

The scientific program was the next order of

business, and Dr. C. C. Sturgis, of the Simpson Memorial Institution, of Ann Arbor, gave a most interesting talk on the subject of "Pernicious Anemia."

## KALAMAZOO COUNTY

Minutes of the November Meeting—The regular monthly meeting of the Kalamazoo Academy of Medicine was held in the rooms of the Academy, November 15, 1927.

Dinner was served at 6:30 and following the dinner the society listened to a very interesting talk, illustrated by lantern slides, given by Professor L. A. Kenoyer on "A Summer in Panama."

The business session was called to order by the president, Dr. Bartholomew at 8:30 p. m.

The minutes of the October meeting were approved as printed in the bulletin.

Dr. Paul L. Schrier and Joseph S. McCarty whose names had been presented for membership at the September meeting, and who had been approved by the board of censors were voted into active membership in the society.

Dr. Wilbur C. Medill was voted into active membership on his request for transfer from the Jackson society. The application of Dr. William N. Kenzie was presented for membership in the society.

The president appointed Doctors Gregg, Lang, Rogers, Van Ness and Goodrich to act as the nominating committee for the annual meeting.

No further business being presented before the society the meeting was turned to Dr. Milard Smith of the University of Michiagn who gave a very interesting and instructive paper on "Arthritis." A general discussion of the subject followed with many questions for Dr. Smith's elucidations.

| Treasurer's Report, Dec. 8, 1927: | Receipts— | |
|---|---|---|
| Dues from members | | $1,858.00 |
| Donations to "float" | | 15.00 |
| Total receipts | | $1,873.00 |
| Disbursements— | | |
| State Society | $1,130.00 | |
| Guests | 76.75 | |
| Bulletins | 161.65 | |
| Postage and Stationery | 120.00 | |
| Telephone and Telegraph | 82.85 | |
| Light | 9.25 | |
| Flowers | 10.00 | |
| Insurance | 35.00 | |
| Taxes | 12.00 | |
| Miscellaneous | 219.19 | |
| Total disbursements | | $1,856.69 |
| Excess Receipts over disbursements | | 16.31 |
| Cash on hand, Dec. 28, 1926 | | 794.93 |
| Cash on hand, Dec. 8, 1927 | | $ 811.24 |

Secretary's Annual Report—The past year has been an unusually prosperous and happy one for the Kalamazoo Academy of Medicine. The spirit of harmony has prevailed and with the advent of our new kitchenette and the excellent dining service furnished by our social committee fellowship and friendliness has been a predominate feature of our meetings. It is to be hoped that the spirit may be fostered throughout the years to come.

Live speakers and excellent programs have been an irresistable drawing card contributing their full share to the excellent attendance record for the year.

A Woman's Auxiliary has been organized in connection with the society and their plans speak well for many future benefits to the profession.

A goodly number of new members have been added to our roll and we would again call your attention to their names: L. D. Becker, Ralph B. Fast, Louis L. Gerstner, Joseph S. McCarty, Wilbur C. Medill, C. L. Penoyar, H. R. Pepin, Paul L. Schrier, James H. Swan, T. H. Ransom, F. W. Heyl and Wilbur B. Payne. Nine active members, two associate members and one re-instated.

The angel of death has passed us by; none has moved from our midst; and only one of our former members has deemed the society unworthy of the payment of dues.

As your secretary relinquishes the pen to a more worthy wielder, he wishes to express his appreciation for your loyal support of the past three years and trusts that errors of omission as well as those of commission will be forgotten. Your same loyal support to the new secretary will do much to keep the Kalamazoo Academy of Medicine among the foremost medical societies in the country.

## MUSKEGON COUNTY

At a meeting of the Muskegon County Medical Society, held in the Community room of the Union National Bank, December 9, 1927, the following officers were elected for 1928.

President, Dr. C. J. Bloom.
Vice-President, Dr. S. N. Morford.
Secretary-treasurer, Dr. Louis LeFevre.
Legal Advisor, Dr. George L. LeFevre.
Delegate to the Satte Convention, Dr. V. S. Laurin.
Alternate Delegate, Dr. F. W. Garber, Sr.

The retiring president, Dr. Kniskern, addressed the society, thanking its members for their cooperation during his term of office.

The meeting adjourned at 9:15.

## ALPENA COUNTY

At the regular meeting of The Alpena County Medical Society, held on December 15 the following officers were elected for the year 1928.

President, Wm. B. Newton, Alpena.
Vice-President, J. S. Jackson, Alpena.
Secretary-Treasurer, C. M. Williams, Alpena.
Delegate, State Society, C. M. Williams, Alpena.
Alternate, H. J. Burkholder, Alpena.
Legal Representative, E. L. Foley, Alpena.

The report of the Secretary revealed the Socity in fine condition financially and otherwise, with a membership of 18. There were 12 regular meetings, and two called meetings, held during the year . Two reciprocal meetings with other Societies were held, one with The Northern Michigan Medical Society, at Indian River, and the other with The Bay County Society. During the past year we had the pleasure of a visit from out tSate Commissioner of Health, accompanied by his lovely wife, at which time our regular meeting gave way for a special meeting in honor of Dr. and Mrs. Keifer. In October, we had a Post-Graduate Conference under the auspices of State Society at which time Doctors Marshall and Randall of Flint and Doctors Brown and Braley of Detroit, gave us a most instructive program

which was very well attended and most heartily received. In November we had our Annual Ladies Night at Lake Winyah Country Club which was a highly enjoyable and well attended meeting.

For some years past The Alpena County Society has enjoyed the reputation of being one of the really live smaller County Societies of the state and we have endeavored in the past year to fully live up to that reputation and we were much pleased to have such a gracious acknowledgement of our efforts as was given by our Councillor, Dr. VanLeuven, in the last issue of The Journal.

Yours for a Happy New Year, filled with effort and crowned with accomplishment.

Wm. B. Newton, Secretary.

## BERRIEN COUNTY

The Berrien County Society had one of the most pleasant as well as profitable meetings of the year on the 30th of November.

This meeting was held at Nile at the Four Flags Hotel, and was preceeded as usual by the monthly dinner.

A short business meeting was held before the paper of the evening. At this time the President announced the committee of Doctors Tonkin, Witt, and Sowers who were to report before the next meeting the nominee's for 1928.

The paper for the evening was given by Dr. Louis J. Hirschman of Detroit on "The Rational Treatment of Hemorrhoids". Although this talk was of primary importance to Proctologists and Surgeons, yet it was made through Dr. Hirschman's personality, extremely interesting to the general practitioner.

His slides were excellent and his explanation of technic was so well given that the talk was more than worth the while of all those present.

The meeting was largely attended and there were several visiting men from the South Bend Society present.

A vote of thanks was given Dr. Hirschman by the Society for the excellence and interest of his paper.

W. C. Ellet, Secretary.

## HIGHLAND PARK PHYSICIANS CLUB

On December 1, 1927, the Highland Park Physicians Club held their Second Annual Clinic, and the following program was given before 300 members of the Medical profession of Michigan, Ohio and Ontario.

*Morning Session*

9:00-10:00—Demonstration of setting of fractures by moving pictures.

Dr. George Ewart Wilson, Toronto; head of Surgical Department, St. Michael's Hospital.

10:00-11:00—Address and Lantern Slide Demonstration, "The Orthopedic Treatment of Poliomyelitis."

Dr. Edwin Warner Ryerson, Chicago.

11:00-12:00—Address and Lantern Slide Demonstration, "Unforseen Deaths from Diseases and the Associated Conditions Found Post Mortem."

Dr. E. R. LeCount, Chicago; Professor and Head Department, Pathology Rush Medical College.

12:00-1:00—Clinic. The Story of Peptic Ulcer and its Surgical Management.

Dr. Arthur Dean Bevan, Chicago; Professor and Head of Department Surgery, Rush Medical College.

1:00-2:30—Buffet Luncheon by the Highland Park General Hospital.

*Afternoon Session*

2:30-3:30—Clinic with Lantern Slide Demonstration, "The Relation of Oto-Laryngology to General Practice."

Dr. Millard F. Arbuckle, St. Louis; Professor of Oto-Laryngology at Washington University School of Medicine.

3:30-4:30—Clinic with Lantern Slide Demonstration, "Cancer of the Stomach."

Dr. F. N. G. Starr, Toronto; President of the Ontario Medical Society.

4:30-5:30—Address, "Chronic Infections of the Urinary Tract", Dr. Edward Cathcart, Ann Arbor, Assistant Professor Surgery, University of Michigan Medical School.

*Evening Session*

6:30—Dinner.

8:30—Address, C. E. Gettins, Mayor Highland Park.

Address, "Our State Society's Interest in the Individual Physician.

Dr. Herbert E. Randall, Flint, President Michigan State Medical Society.

Address, Dr. Angus McLean, Detroit.

Address, Dr. F. N. G. Starr, Toronto.

Address, "The Abdominal Emergencies", Dr. George E. Wilson, Toronto.

Executive session.

Election of officers.

At the executive session the following officers for the year 1928 were elected unanimously.

Dr. William N. Braley, President.
Dr. C. C. Vardon, Vice-President.
Dr. Chas. J. Barone, Secretary.
Dr. Melvin O. Kernick, Treasurer.

It is the intention of the Highland Park Physicians Club to continue the annual clinics since the first two were very successful. A clinic to be a success has to contain good talent, must have good clinical material, and lastly must be well attended.

For the attendance, I want to take this opportunity to thank those that came to our clinics. Next year our plans are for as good, if not a better clinic, and I hope the physicians from the Michigan State Medical Society will support it as well as they have supported our past efforts.

Chas. J. Barone, Secretary.

## KENT COUNTY

The Kent County Medical Society has held two meetings each in October and November. All these meetings were held in the Solarium of Butterworth Hospital. At the first meeting, October 12, a clinical program was presented, consisting of the following:

1. "Acute Pancreatitis", A. J. Baker, M. D.
2. "Unusual Case of Foreign Body in the Eye", John R. Rogers, M. D.
3. "Case Report of Hemolytic Jaundice, Complicated with Pregnancy, and its Treatment", Margaret Miller, M. D., Leon C. Bosch, M. D.

At this meeting, Dr. Guy L. Kiefer, State Commissioner of Health, discussed the need for the establishment of a county health department in Kent County. He wished to obtain the approval

of the Kent County Medical Society for this project and advocated its establishment for these reasons, namely: First, the need for a medical health officer; second, the need of adequate medical supervision for the nursing staff; third, to protect the county better against the spread of contagious disease; fourth, to promote health education. He further stated that funds for this organization could be obtained in part by assistance from the State of Michigan and the Rockefeller Institute. The remaining amount due he felt would only increase the tax about 15 cents on a $5,000 valuation. The total cost of this organization would not greatly exceed the present amount expended by the various townships; if so established, this would be the first county health organization in the state of Michigan.

The establishment of this county health department was approved by the Society, but failed of passage by the Board of Supervisors of Kent County.

The chairman of the committee on clinics, Dr. John R. Rogers, reported from his committee a recommendation that the following appointees constitute, along with the present committee on clinics, a joint committee on clinics, the members recommended being representatives from the respective clinics names:

Infant Feeding—T. D. Gordon.
Tuberculosis—E. N. Nesbitt.
Butterworth Hospital—A. J. Baker.
St. Mary's Hospital—E. B. Anderson.
Blodgett Hospital—D. M. Morrill.
Orthopedic Clinic—John T. Hodgen.
Prenatal Clinic—A. M. Campbell.

It is the intention that the duties of this augmented committee shall be not only the investigation of clinic abuses, but that its more important function will be to inform itself on all matters pertaining to clinics, and to report to the medical society from time to time the result of its investigation.

On the evening of October 25, 1927, the following program was rendered:

1. "Practical Points in Prenatal Care", (with lantern slides), E. B. Andersen, M. D.

2. "Some Remarks on Traumatic Surgery", (with lantern slides), R. F. Webb, M. D.

3. "The More Common Infections of the Kidney", L. M. McKinley, M. D.

The program on November 9 was as follows:

1. "Child Placement for Adoption as a Modern Scientific Procedure", Miss Helen I. James, Secretary of the Michigan Children's Aid Society.

2. "Surgery in Arthritis Deformans; Amidoxyl as and Adjunct in Treatment, Showing Case with End Results of Hip Arthroplasty", J. C. Foshee, M. D.

3. "Certain Intestinal Conditions in Cases of Obscure Fever", Merrill Wells, M. D.

At the meeting on November 25, 1927, a communication was read from the Director General of the American College of Surgeons, Dr. Franklin H. Martin, which contained the text of a resolution conveying the thanks of the Surgical Section of the Royal Society of Medicine for the demonstration of American surgery and hospitality shown by American physicians and surgeons, in connection with their visit to Grand Rapids.

The following program was given:

1. "Thydoidectomy: Its Relation to the Cure of Thyroidtoxicosis", W. A. Hyland, M. D.

2. "The International Goitre Conference at Berne, Switzerland", illustrated with moving pictures, Elmer W. Schnoor, M. D.

3. "The Heart in Toxic Goiter", Henry J. VandenBerg, M. D.

The following physicians have been elected to membership in the Kent County Medical Society since its first meeting in September; namely: L. M. McKinlay, G. R. National Bank building; A. R. Hufford, Medical Arts building; F. J. Bean, Grand Rapids Clinic; T. P. Bishop, Medical Arts building; F. J. Bull, G. R. National Bank building; J. TenHave, 750 Leonard; John F. Yonkman, Metz building; C. E. Osborne, Medical Arts building; William R. Torgerson, Grand Rapids Clinic.

H. T. Clay, Secretary.

## LENAWEE COUNTY

The year of 1927 has ended so far as the Lenawee County Medical Society is concerned in an active way. We feel that we have had a fairly good year, and that we are ready to begin a bigger year for 1928. We have our program all planned and the speakers engaged for over half the year.

We had 11 meetings, and all of them were well worth attending. Our attendance at meetings this year has not been as good as it might have been, but for some reason we have been unable to learn, there are some members who just do not seem to remember when we have a meeting.

The Annual Banquet of the Society was held at the Lenawee Hotel at Adrian, on the evening of Thursday December 15, 1927. The members and their wives attended to the number of 40. Our speaker was Dr. R. C. Longfellow of the Toledo Clinical Laboratory. He spoke on the subject of "Everyday Life in Egypt". He has spent several seasons in Egypt, Palestine and European countries. During one of his trips to Egypt he acted as House Physician to the Khedivial Hotel in Cairo, and it was largely from the experiences gained there that he told his story. He opened his talk by saying that he intended giving us some facts not written in the books, magazines, or steamship folders, and he certainly kept his promise. His discription of the methods of the native physicians and healers was like turning back the pages into ancient history. He discribed the sanitary conditions and the progress that is being made to improve them. He advised anyone contemplating a trip to Cairo, and he said that applied to Egypt generally, to remember that there was no pure water, except in bottles, no pure milk, and no raw fruit or vegetables that were safe to eat. He also said that no one should ever go without more than enough money and then to be very careful what he did with it after he got there. Dr. Longfellow's talk was interesting and instructive and was enjoyed by all who were present, and the Society feels very grateful to him for coming to talk to us.

I am going to enclose with this letter an outline of our program for 1928 giving the names of the speakers where they are known.

The officers and members of the Lenawee County Medical Society wish you the best wishes of the season and hope that your coming year will be successful and pleasant.

Outline program of the Lenawee County Medical Society, 1928:

January—Society entertained by Dr. Esli T. Morden at the Adrian club. Election of officers

for 1928. Moving pictures and story of Canadian Hunting Trip, Dr. H. H. Hammel of Tecumseh.

February—"Management of Fractures of the Fore Arm and the Femur", Dr. Carl Badgley of Ann Arbor.

March—"Reminiscences of My Surgical Experience", Dr. Angus McLean of Detroit.

April—"Inflammation of the Kidney",Dr. James E. Davis of the Detroit College of Medicine and Surgery.

May—"Diseases of the Anus and Rectum", Dr. E. G. Martin of Detroit.

June—Annual Joint Meeting with Fulton County Ohio. "Malarial Treatment of Paresis." July or August—Annual Picnic.

September—"The Management of the Neurotic Woman". Speaker to be announced.

October—"Intestinal Obstruction", Dr. C. E. Boys of Kalamazoo.

November—"The Heart". Speaker to be announced.

December—Annual Banquet.

R. G. B. Marsh, Secretary.

## INGHAM COUNTY

At the date of compiling this report (December 5, 1927) the Society has 83 members in good standing as compared to 89 members in 1926, and as compared to 96 members in 1925. In other words there has been a loss of 14 members in the last two years.

This loss is due to several conditions. The principal one of which is non-payment of dues. This may be due to the increase in dues or to a delinquency on the part of the Treasurer in the matter of collecting.

During the year we have acquired eight new members, four being elected and four being transferred from other Societies. Dr. McGillicuddy and Dr. Davenport were reinstated after one years leave of absence. Dr. L. Boyd and Dr. C. H. Benning left for other cities. We lost one member, Dr. W. H. Witter of Cleveland, Ohio, who died following a gall bladder operation.

We have at the time of this report nine active members not in good standing because of failure to pay their annual dues.

There were held during the year, 18 meetings of various types. The average attendance of these meetings was 34 as compared to 44 of last year, or 41 per cent as compared with 57 per cent last year. This may be due to several reasons. Principally to the fact that we have monthly staff meetings at both hospitals and I am inclined to feel that under our present local arrangements we are having too many meetings of not very prominent interest and it is therefore an impossibility to get much of an attendance. Then, too we have been hampered by holding several joint meetings with the hospital staff, with the American Chemist Society, with the Michigan Tuberculosis Association and Trudeau Society. All this has a tendency to blend our Society with various organizations and takes away any concentrated effort of the Society committee to serve as they should.

At one of our last meetings an out of town member who travels about 15 miles to attend, and who always is present was asked, what we could do to get other out of town members to attend more regularly. He answered by saying, "Get your own members out." This surely has been our trouble during the past year. Unless every member resolves to attend meetings regularly our meetings will be poorly attended, because a Secretary can not call every member individually for every meeting and a postal card should be sufficient.

The big recommendation that our Secretary can make is to have a full attendance at every meeting or the Society will fail to serve its purpose.

In order to facilitate this work, I am going to recommend that the Society elect an individual Secretary, and an individual Treasurer so that the work of each office can be more efficiently carried out.

C. F. DeVries, Secretary.

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The Annual Meeting of the Ingham County Medical Society was held at the Hotel Olds, December 6, 1927. The following officers were elected for the ensuing year:

President, B. Karl Brucker, Lansing.
Vice-President, L. C. Towne, Lansing.
Secretary, R. E. Goldner, Lansing.
Treasurer, Howard Wilson, Lansing.

The office of Secretary-Treasurer was divided. Heretofore it had been filled by one man.

Following the business meeting there was a banquet for the physicians and their wives. Speakers of the evening were the Rev. Father Gabriels and Dr. Guy Kiefer.

Our Society would appreciate this publication in the next issue of the "Journal".

R. E. Goldner, Secretary.

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# BOOK REVIEWS AND MISCELLANY

Offering Suggestions and Recommendations

CLINICAL LABORATORY PROCEDURES — George L. Rohdenburg, M. D., Director of Laboratories, Lenox Hill Hospital, Misericordia Hospital, Beth David Hospital, New York. The Macmillan Company, New York, Publishers. Price $2.25.

The present volume is a collection of laboratory methods which in the hands of the writer have shown their relative simplicity and clinical accuracy over a period of years of actual use. Where several methods are known or are in common use, that one has been arbitrarily selected which practical experience has indicated to be preferred. Some knowledge of laboratory procedure on the part of those using the volume is presupposed. An effort has been made to present concisely such procedures as are frequently undertaken in routine work.

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THE DIABETIC LIFE—R. D. Laurence, Kings Hospital, London. Third tdition. Price $2.50. P. Blackstone Son & Co., Philadelphia.

An excellent guide for the general practitioner supplying well directed methods and measures.

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DISEASES OF THE SKIN: Henry H. Hazen, M. D. Third edition, 248 ilustrations, 572 pp. Price $10.00. C. V. Mosby Co., St. Louis, Mo.

This third edition maintains the excellence of former editions with a revision of the text. As such then it is a very satisfactory diagnostic and treatment guide for the general practitioner.